

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16707

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in **page 3** and **page 4**, then please remove carbon papers. **Pages 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		16694				2				16707	
1. DECEASED-NAME (Type or print)		First Wayne	Middle Lee	Last Ahern			2. DATE OF DEATH Month Dec Day 28 Year 68		2 nd HOUR 8 P.M. M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 28, 1968		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 157 Wood			
14. FATHER'S NAME First Harry		Middle J	Last Ahern	15. MOTHER'S MAIDEN NAME First Sandra		Middle Duckworth		Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Harry J. Ahern-Westernport, Md.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Immature birth									
777 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Premature postpartum (28 weeks)								10 minutes	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1968, to Dec. 28, 1968, that (I) (we) last saw the deceased alive on Dec. 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. Paige Strong, M.D.		22c. DEGREE DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		22d. MED. DIRECTOR <input type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec. 28, 1968			
22d. PHYSICIAN'S NAME (Type) A. Paige Strong		22e. ADDRESS Frostburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City or Town) Westernport		(County) Md.		(State)	
24. FUNERAL DIRECTOR El Breal		ADDRESS Westernport, Md. 21562		25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 30M REV. 1											

Birds without

annual (otherwise) until the next year.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16708

16695

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Cora	Middle Barley	Lost	2a. DATE OF DEATH Month Dec.	Doy 24	Year 68	2b. HOUR 10:10 P.M.		
3. SEX Female		4. RACE White	5. DATE OF BIRTH 7/1/83	6. AGE (In years last birthday) 84 85 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN		
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Allegany	Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 313 Cecelia St.					
14. FATHER'S NAME First James Martin		15. MOTHER'S MAIDEN NAME First Barbara Mulligan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Florence Reed, Cumberland, Md. Niece	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129		Neutro mural Demyelination approx. 1/2 due to, or as a consequence of Arteriosclerosis many years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4000 mg. Digitalis with mental deterioration										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from May 5, 1967, to Dec. 24, 1968, that (I) (we) last saw the deceased alive on Dec. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 12-30-68		
22b. SIGNATURE John Scarpelli		22d. PHYSICIAN'S NAME (Type) John Scarpelli	22e. ADDRESS St. Mary's Hospital Cumberland Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County)	(State)				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR JAN 2	25b. REGISTRAR'S SIGNATURE Charles Judge						

18781

680

20, 1911.

Spent the day in the city.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 4 may be retained by the hospital or attending physician. Then please remove carbon papers, boxes 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16695													
1. DECEASED NAME (Type or print)	First		Middle	Lost	2d. DATE OF DEATH		Month	Day	Year	2b. HOUR			
	Preston		Bennett		Dec. 24		1968			10 AM 12 Noon			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male	White		Sept. 17, 1887		81 YRS.		MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH					
West Virginia	U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Allegany					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12d. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY								
Cumberland	Sylvan Retreat		Farmer (Ret.)		Farm								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER									
Maryland	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	525 Fort Avenue									
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Last					
	Dice	Bennett		Emma Vint		more							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.		17. INFORMANT		Address								
no	236 58 0876		Mrs. Grace Price, Cumberland, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> APPROX 1m										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>dr. A.S.H.D</i> MARY 40 yrs (c) <i>Arterio sclerosis</i> many years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 <i>Cerebral arterio sclerosis & mental deterioration</i>													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED		(Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1968, to Dec. 24 19 68, that (I) (we) last saw the deceased alive on Dec. 23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John A. Tupper MD</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-30-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>John A. Tupper MD Memorial Hospital Cumberland, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORIAL North Fork Mem. Cem.		23d. LOCATION (City or Town) Riverton, W. Va.		(County)		(State)					
24. FUNERAL DIRECTOR Byron Kight	ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge								

2001

1945-09-01

PPA

1945-09-01 1945-09-01

1945-09-01

1945-09-01 1945-09-01

00

1945-09-01 1945-09-01 1945-09-01 1945-09-01

1945-09-01 1945-09-01 1945-09-01 1945-09-01

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

16697		16710	
1. DECEASED NAME (Type or print)	First JACK	Middle R.	Last BLAIR
2. DATE OF DEATH Month DEC	Day 13	Year 68	2b. HOUR 350M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 05-07-25	6. AGE (in years last birthday) 43 YRS.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY COUNTY,
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during week working like or not at all) SUPERVISOR (FORESTRY)	12b. KIND OF BUSINESS OR INDUSTRY BOYS CAMP
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. CITY OR TOWN Garrett Lonaconing	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER (RURAL)
14. FATHER'S NAME First ROBERT	Middle BLAIR	15. MOTHER'S MAIDEN NAME First (STEVENS)	Middle MARY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO. 218-16-4680	17. INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD.	Address MD. 21502
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONONARY THROMBOSIS			
4109 DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost.			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
4201			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 8-5- , 19 68 , to 8-9-1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 8-9-1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.			
22b. SIGNATURE <i>D. Matthew Kauf</i>	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-13-68	
22d. PHYSICIAN'S NAME (Type) MATTHEW KAUFMAN, M.D.	22e. ADDRESS 912 SETON DR., CUMB., MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/15/1968	23c. NAME OF CEMETERY OR CREMATORIAL Memorial Park	23d. LOCATION (City or Town) Frostburg, Md.
24. FUNERAL DIRECTOR EICHORN FUNERAL SERVICE, 8 E. MAIN ST., LONACONING	ADDRESS 16 DEC 16 1968	25a. REC'D. BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE DATE

ICAHN'S FINE ART INC. 11 E. 57TH ST., NEW YORK

1250 S. 11TH ST., PHILADELPHIA, PA.

KEY

HOTEL

TRAVEL

(STENGRAPH)

MAIL

PHOTO

200

100

100

100

100-125

100

100

100

UNITED STATES

1900-1905 (1901) 1901-1905 (1902) 1901-1905 (1903) 1901-1905 (1904)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 4413 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16711

1. DECEASED NAME (Type or Print)		First Robert	Middle Fulton	Last Boden	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Dec.	Day 25,	Year 1968	2b. HOUR 11:00 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 25, 1898	6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Dec. Day 30, Year 1968			2d. HOUR 11:30 A.M.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 324 Beall St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gas driver			12b. KIND OF BUSINESS OR INDUSTRY Welfare Organization		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 324 Beall St.				
14. FATHER'S NAME Joseph		First D.	Middle Boden	Last	15. MOTHER'S MAIDEN NAME Julia	First --	Middle --	Last Hartley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, <input type="checkbox"/>		16b. SOCIAL SECURITY NO. U.W. # 182		17. INFORMANT Mr. Douglas M. Boden 323 Avirett Ave. Cumb. Md.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			CORONARY OCCLUSION CORONARY SCLEROSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MEDICAL CERTIFICATION										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED Dec. 30, 1968		
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>Benedict Skitarelic</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/1/69	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park,		23d. LOCATION (City or Town) Cumberland, Allegany		(County) Md.	(State)		
24. FUNERAL DIRECTOR		ADDRESS H. Wayne George 202 Greene St. Cumb. Md.		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 6 1969 <i>Charles George</i>				

14781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

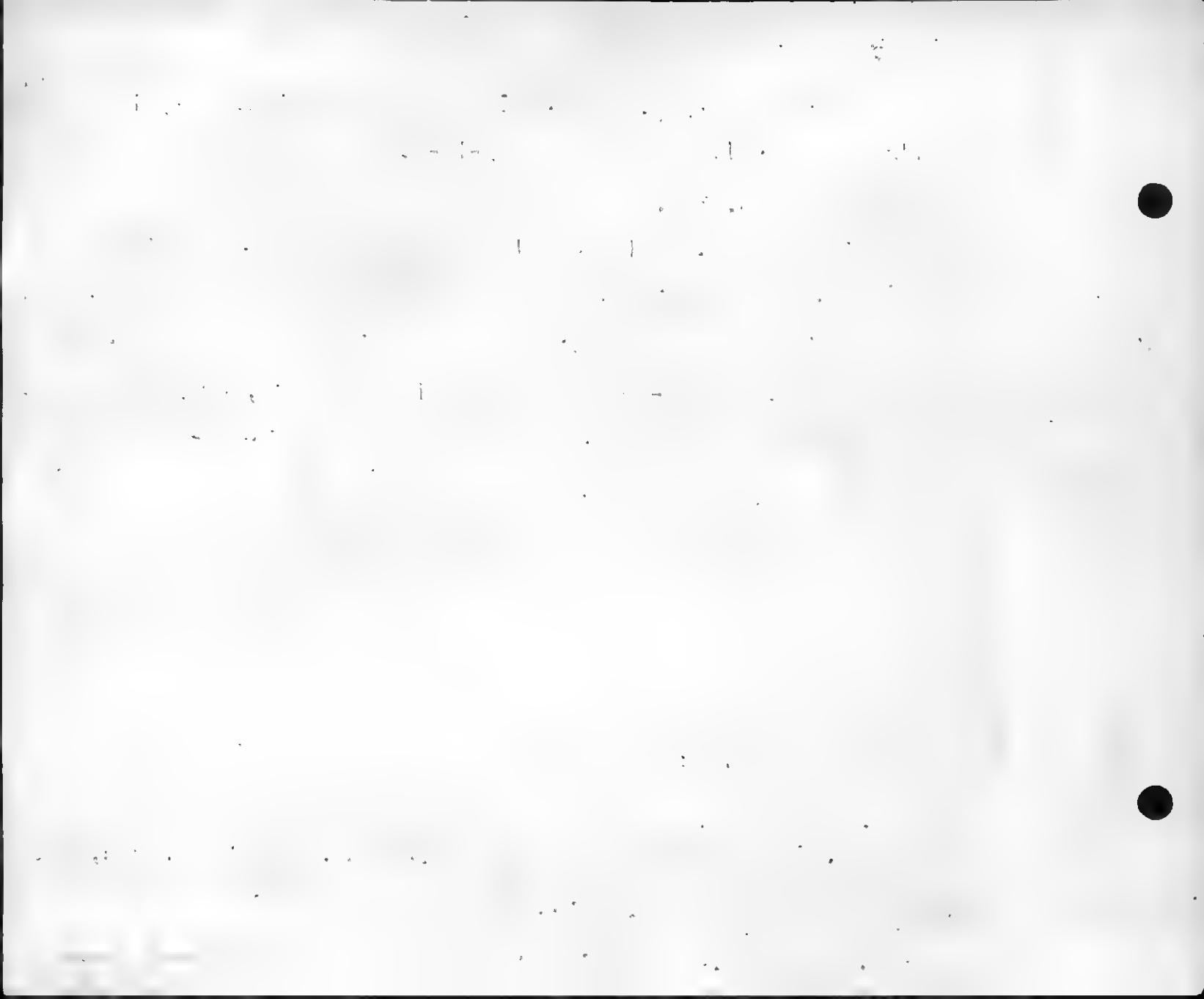
CERTIFICATE OF DEATH

16712

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First LESTER	Middle Sylvester	Last BOGGS	2a DATE OF DEATH DECEMBER 29, 1968	2b HOUR 11:05		
3. SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 9-14-06		6. AGE (In years last birthday) 62	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH ALLEGANY				
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give name and address) MEMORIAL HOSPITAL		12a USJAL OCCUPATION (Kind of work done during most of work no life, even if retired) FREIGHT DEPOT CLERK RAILROAD	12b KIND OF BUSINESS OR INDUSTRY				
13a USJAL RESIDENCE (Where deceased resided, if institution, Residence before admission) STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS YES	13e STREET AND NUMBER 307 JEFFERSON ST.				
14 FATHER'S NAME First HARRY	Middle BOGGS	Last	15. MOTHER'S MAIDEN NAME First NANCY	Middle	Last CRABTREE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b SOCIAL SECURITY NO (If yes give no. or dates of service) WW 2	16c INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Lymphatic Leukemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr - 5 mos</i>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Cardiac Failure</i>		4 hrs						
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 1967, to <i>Dec 28</i> , 1968, that (I) (we) last saw the deceased alive on <i>Dec 27</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Clay Durrett</i>		22c. DATE SIGNED <i>1/31/68</i>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22e. ADDRESS 236 VA. AVE., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, BEMERAL (Specify)	23b. DATE 1/1/1969	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Near Cumberland (County) Alleg (State) Md					
24. FUNERAL DIRECTOR <i>Charles E. Hafer</i>	ADDRESS Charles E. Hafer, 230 Balto Ave Cumberland Md		25a. REC'D BY REGISTRAR DATE JAN 3 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

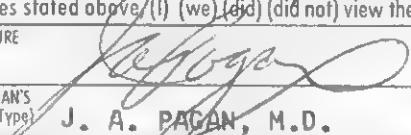
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16713

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, and file page 3 with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	16700	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					26 HOUR
		CERTIFICATE OF DEATH					12 Day 21 Year 68 1:58P
1. DECEASED NAME (Type or print)		First LEONA	Middle MARGARET	Last BONE	2d. DATE OF DEATH Month Dec	Year 68	26 HOUR
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH 2-19-05		6. AGE (in years last birthday) 63	IF UNDER 1 YEAR MONTHS YRS	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USJA. OCCUPATION (Kind of work done during day, if working, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USJA. RESIDENCE (Where deceased resided, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. NSIDE CTY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 151 PARK AVENUE		
14. FATHER'S NAME First JAMES		Middle WARNICK	Last	15. MOTHER'S Maiden Name First GROVE	Middle RHODA	Last WARNICK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 214-07-6213	17. INFORMANT HOSPITAL RECORDS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 76 hrs.		
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 cerebral hemorrhage		DUE TO, OR AS A CONSEQUENCE OF (b) hypertension		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 12/19/68 , to 12/21/68 , that (I) (we) last saw the deceased alive on 12/20/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE 		DEGREE <input type="checkbox"/> M.D. <input type="checkbox"/> D. RECTOR	ATTENDING PHYS. <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/21/68		
22d. PHYSICIAN'S NAME (Type) J. A. PAGAN, M.D.		22e. ADDRESS 1068 NATIONAL HIGHWAY, LAVALE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-24-68	23c. NAME OF CEMETERY OR CREMATORIAL FBC MEMORIAL PARK	23d. LOCATION (City or Town) FROSTBURG	(County) MONTGOMERY	(State) M.D.	
24. FUNERAL DIRECTOR DURST FUNERAL HOME,		ADDRESS FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE DEC 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

0 = 1 - 0

A = 2

2 162

E 22

R u

2 162

0 2

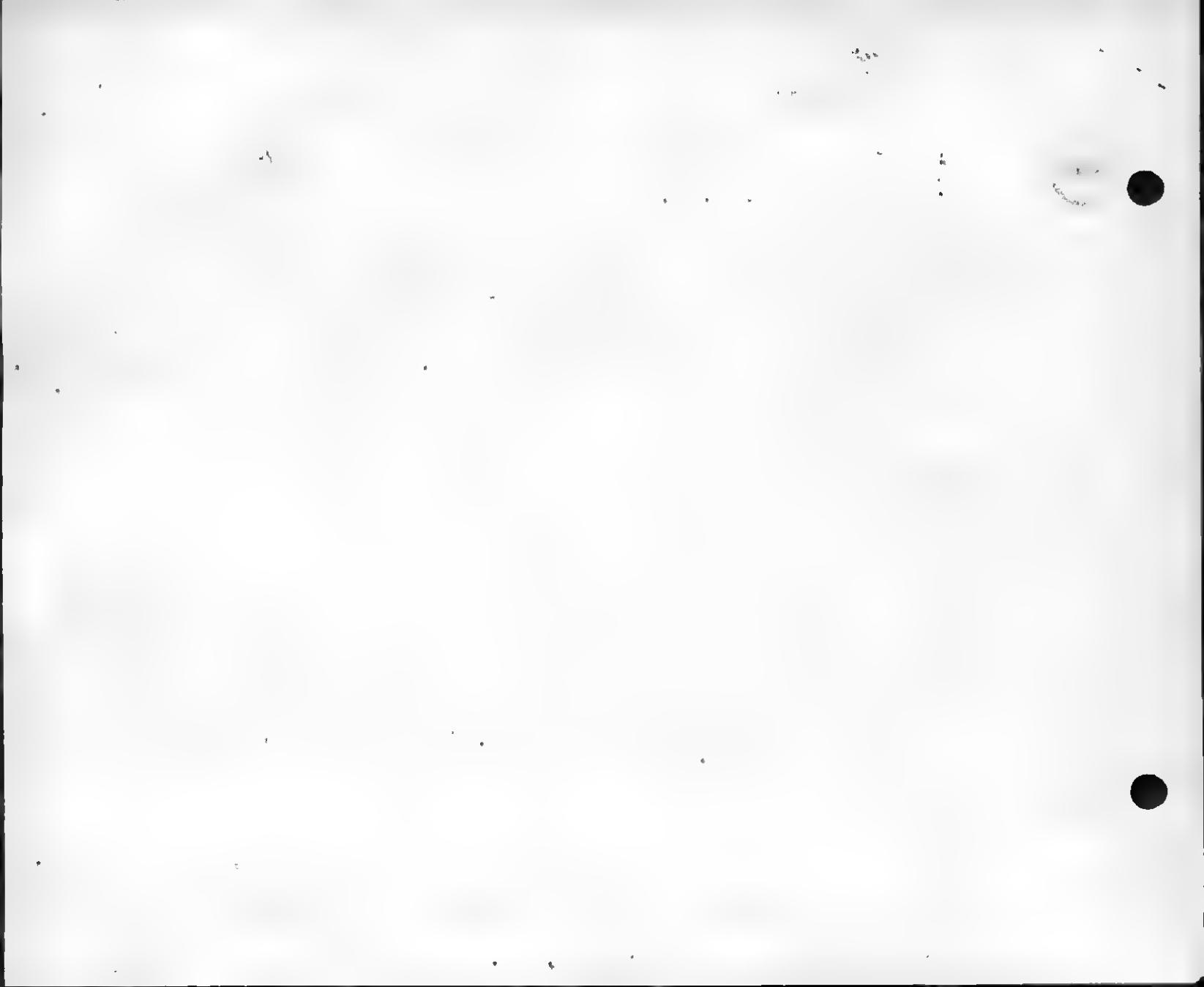
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

16701		16714	
1. DECEASED NAME (Type or print)		First Cornelius	Middle J.
2. SEX		3. RACE	4. DATE OF BIRTH 12/25/1892
5. BIRTHPLACE (State or foreign country) Maryland		6. CITIZEN OF WHAT COUNTRY? U. S. A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years last birthday) 75		9. COUNTY OF DEATH Allegany County	10. DATE OF DEATH Month Day Year December 19, 1968
11. IF UNDER 1 YEAR MONTHS DAYS		12. IF UNDER 24 HRS. HOURS MIN	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Coal Miner			
12b. KIND OF BUSINESS OR INDUSTRY Coal Mining			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER Route #1			
14. FATHER'S NAME First Kennard		Middle Broadwater	15. MOTHER'S MAIDEN NAME First Anna
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. P.O. Box 599, Allegany County Infirmary records.	17. INFORMANT P.O. Box 599, Address Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD = congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause 4139 Pulmonary embolism lost (b) Carcinoma Prostate DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Prostate			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221			
19a. DATE OF OPERATION 4221		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1968 to Dec. 19, 1968 , that (I) (we) last saw the deceased alive on Dec. 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE George M. Sonnen		22c. DATE SIGNED 1968	
22d. PHYSICIAN'S NAME (Type) George M. Sonnen		22e. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Greens Cemetery
23d. LOCATION (City or Town) "Rural"		(County) (State) Lonaconing Garrett Md	
24. FUNERAL DIRECTOR George Eichhorn		25a. ADDRESS Lonaconing, Md.	25b. REC'D BY REGISTRAR DEC 26 1968
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16715

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, Pages 1 and 2, from the back of this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First GRAYSON	Middle S	Last BURKE	2a. DATE OF DEATH Month Dec	Year 1968	2b. HOUR 8:05A M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-23-02		6. AGE (in years last birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Carman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13c. CITY OR TOWN ALLEGANY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 900 REAR OLDTOWN RD.	
14. FATHER'S NAME First SAMUEL		Middle BURKE	Last	15. MOTHER'S MAIDEN NAME First VALLIE		Middle	Last COFFMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 705-05-4550		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diabetes Mellitus & Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2509</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Car accident</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.R. No. <i>Capitol Street</i>		City or Town <i>Cumberland</i>	County <i>Allegany</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>12/24/68</i> , 19 <i>68</i> , to <i>12/25/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/24/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.							
22b. SIGNATURE <i>R. J. Williams</i>		22c. DATE SIGNED <i>12/24/68</i>					
22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 28, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 4 may be retained by the hospital or attending physician.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)	First MARIA	Middle	Last CAVALLARO	2d DATE OF DEATH Month DECEMBER 24, 1968	2b PM/AM 2:55M
3 SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 5-5-1889	6 AGE (In years last birthday) 79	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) ITALY	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give state) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most time) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN WESTERNPORT	13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 213 MARYLAND AVE	
14. FATHER'S NAME First JOHN	Middle LUPIS	15 MOTHER'S MAIDEN NAME First TERESA	Middle ALVARO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Year of Unknown No	16b. SOCIAL SECURITY NO. 614X	17 INFORMANT MEMORIAL HOSPITAL, CUMB. MD.	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pemphigoid Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ Due to, or as a consequence of (c) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) No					
19a. DATE OF OPERATION 10/4/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		
22a. I certify that (I) (this hospital) attended the deceased from 13 Dec., 1968 , to 24 Dec., 1968 , that (I) (we) last saw the deceased alive on 24 Dec., 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>Dr. Van C. Kroll Has pronounced pt dead</i>					
22b. SIGNATURE <i>Mark M. Kroll M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 26 Dec. 68
22d. PHYSICIAN'S NAME (Type) MARK M. KROLL DR. XXXXXXXX		22e ADDRESS 110 DOCK S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL CREMATION, Burial (Specify) Burial		23b. DATE 12/28/68	23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cem.	23d. LOCATION (City or Town) Westernport Allegany Md.	(County) (State)
24. FUNERAL DIRECTOR <i>Mark Kroll</i>		ADDRESS Westernport, Md. 21562	25a. REC'D BY REGISTRAR DATE DEC 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



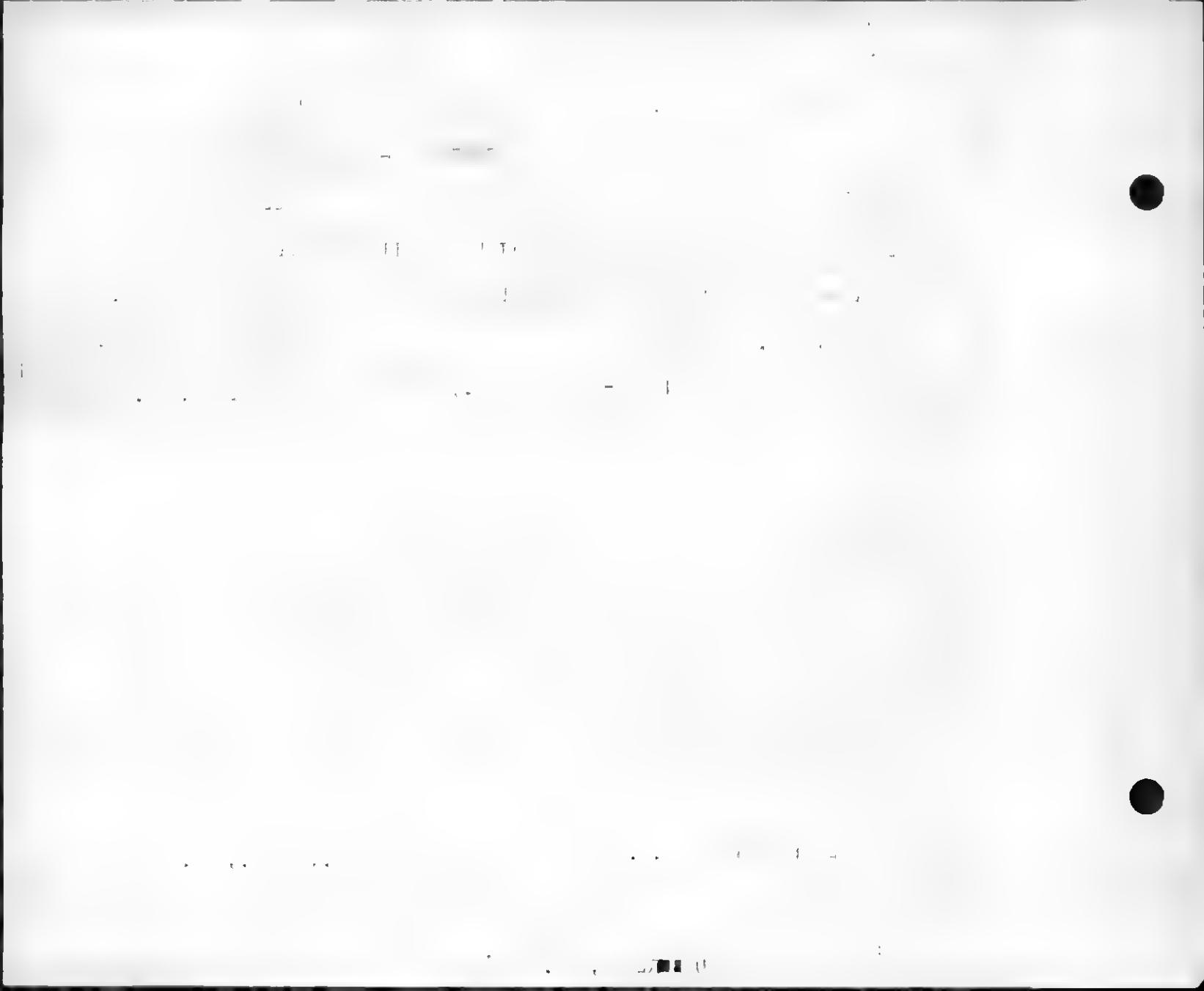
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16705

16717

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed by the funeral director, page 3 should be detached for use as the air-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First MARIE	Middle C.	Last CHAMBERS	2a. DATE OF DEATH DECEMBER 4, 1968	2b. HOUR M	
3. SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 4-28-1904	6 AGE (In years at time of death) 84	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH ALLEGANY	
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TICKET SELLER		12b KIND OF BUSINESS OR INDUSTRY MOVIE	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 133 SO LIBERTY ST.	
14 FATHER'S NAME First FREDERICK E. KORNHOFF				15. MOTHER'S MAIDEN NAME First MARY ELIZABETH		Middle Last CASPERLINE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 213-22-3384		17. INFORMANT SACRED HEART HOSPITAL HOSP., CHART		Address 900 SETON DRIV CUMBERLAND, MD. 21502	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute coronary occlusion 41-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary sclerosis (c) atherosclerosis					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour		1/ month		1/ year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 41-7							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-9-1968, to 12-4-1968, that (I) (we) last saw the deceased alive on 12-4-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. Brings		DEGREE ATTENDING PHYS	22c. DATE SIGNED 12-5-68		MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland Allegany Maryland	(County)	(State)
24. FUNERAL DIRECTOR SILCOX FUNERAL HOME		ADDRESS 404 DECATUR ST CUMBERLAND, MD. 21502	25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (3) 30M REV 1							



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

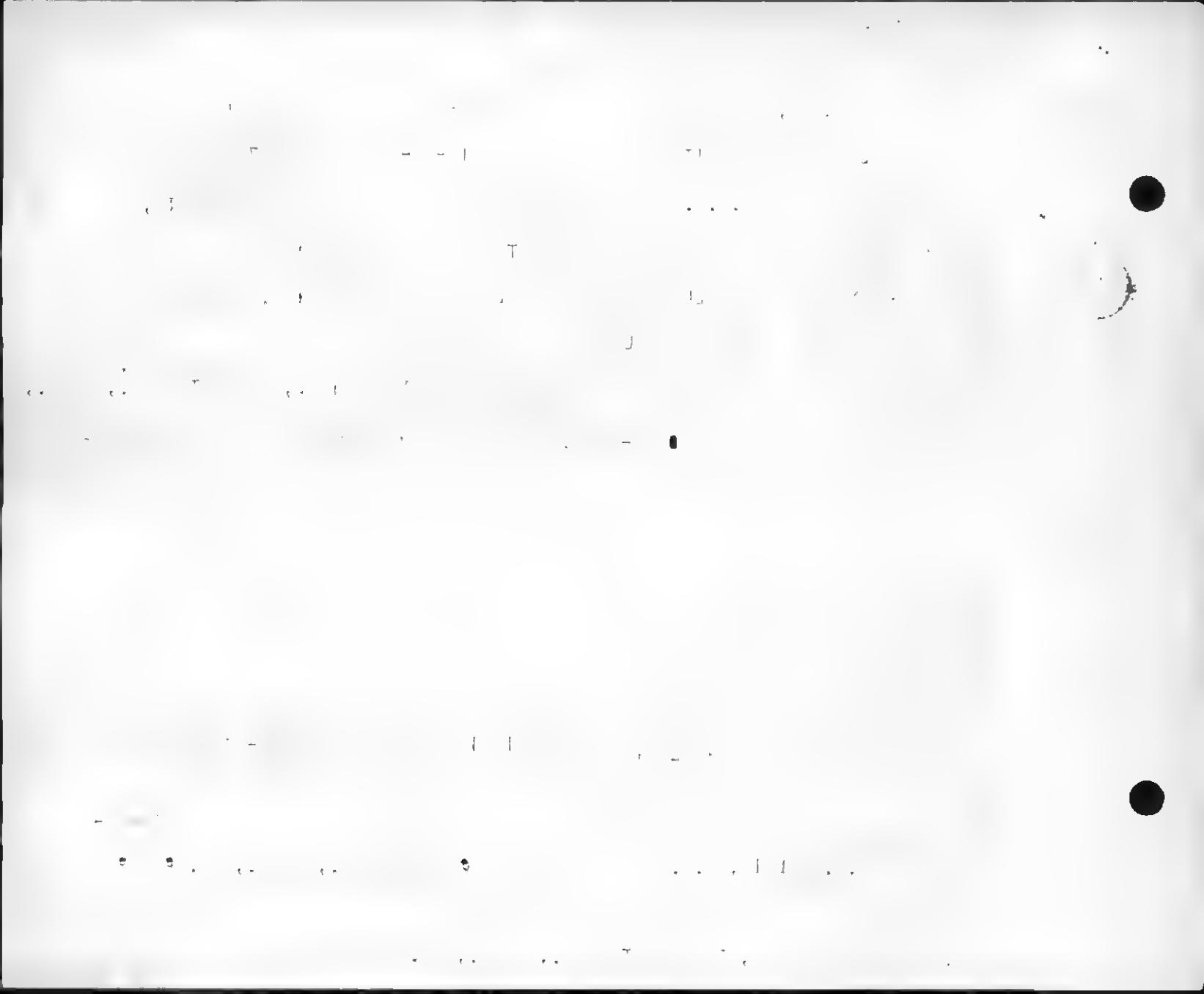
16705 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 File # 407 12/13/68 kk

CERTIFICATE OF DEATH

16718

1 DECEASED NAME (Type or print)	First CLARK,	Middle MARY	Last FRANCES	2a DATE OF DEATH Month 12	Day 11	Year 68	2b HOUR 1:30 P.M.
3 SEX FEMALE	4. RACE WHITE	5 DATE OF BIRTH 10-08-98		6 AGE (In years lost birthday) 70	7 IF UNDER 1 YEAR MONTHS YRS.	8 IF UNDER 24 HRS. DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY COUNTY, Md.	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY Own Home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 111 N. PAW PAW WAY			
14 FATHER'S NAME First CHARLES	Middle WELCH	15 MOTHER'S MAIDEN NAME First (MURPHY) SUSAN	Middle WELCH	Last WELCH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b SOCIAL SECURITY NO 215-20-5501	17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502	Address MD. 21502				
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADENO-CARCINOMA OF UTERINE CERVIX				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 MOS			
18c Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State	
22a I certify that (I) (this hospital) attended the deceased from 12-3 , 19 68 , to 12-11, 1968 , that (I) (we) last saw the deceased alive on 12-11 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>R.W. Ballin, M.D.</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 12-11-68		
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22e ADDRESS 62 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/68	23c NAME OF CEMETERY OR CREMATORIAL I. O. O. F. Cemetery	23d LOCATION (City or Town) Elk Garden	(County) Mineral	(State) W.VA	
24 FUNERAL DIRECTOR KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB., MD.		ADDRESS DEC 16 1968	25a REG'D BY REGISTRAR Charles Judge	25b REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16719

16708

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First NERINE	Middle R.	Last CONROY	2a. DATE OF DEATH Month 12 Day 22 Year 68	2b. HOUR 9:28 AM	
3. SEX FEMALE		4 RACE WHITE	5. DATE OF BIRTH 01-22-07		6 AGE (in years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWF		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 20 VALLEY STREET	
14. FATHER'S NAME First WILLIAM		Middle MORRISON	15. MOTHER'S MAIDEN NAME First EVA		Middle ROSS	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. NONE	17. INFORMANT PTS. HOSPITAL CHART SACRED HEART HOSPITAL		Address 900 SETON DRIVE CUMBERLAND, MD. 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i> 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) <i>ruptured berry aneurysm</i> stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>250x Darien mictu</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Clarence J. Vincent - M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) CLARENCE VINCENT, M.D.		22e. ADDRESS 912 SETON DRIVE CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 26, 1968	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY		23d. LOCATION (City or Town) CUMBERLAND, MD.	(County)	(State)
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME		ADDRESS 309 DECATUR ST. CUMBERLAND, MD. 21502	25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

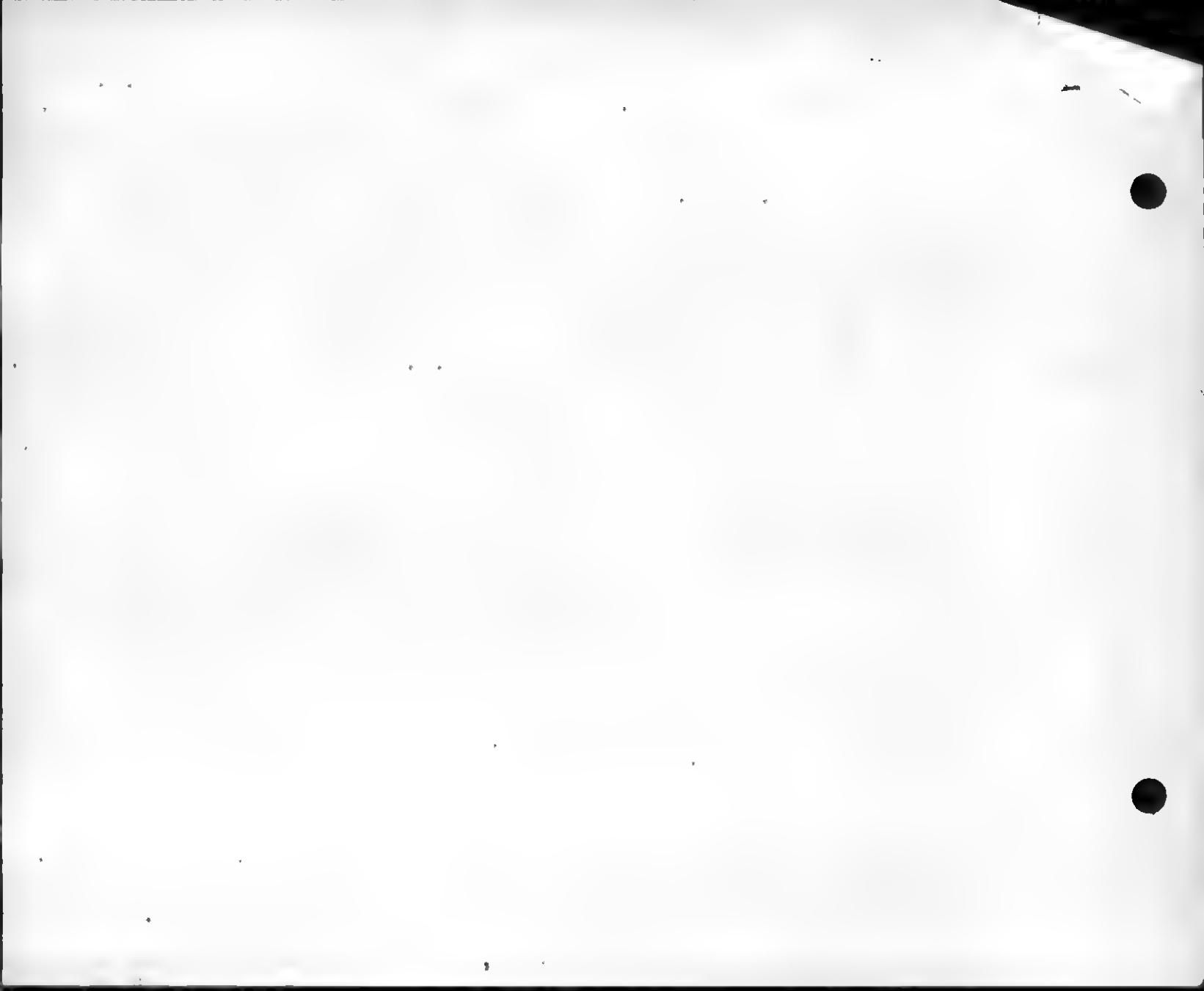
CERTIFICATE OF DEATH

16720

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Return page 3 and this certificate, along with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Russell	Middle W.	Last Cutter	2a DATE OF DEATH at 6:35 P.M. Month Dec. Day 24, 1968 Year P.D.	2b HOUR P. M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 15, 1893		6. AGE (in years last birthday) 75 YRS.	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	2d HOUR MONTHS 0
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany County				
10 CITY OR TOWN OF DEATH Cumberland Allegany County Infirmary Retained		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Allegany County Infirmary Retained		12a USUAL OCCUPATION (Kind of work done or not most of working life, even if retired) Celanese		12b KIND OF BUSINESS OR INDUSTRY Celanese	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Allegany	13c CITY OR TOWN Midland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 100 Main Street			
14 FATHER'S NAME First Jacob	Middle Cutter	Last	15 MOTHER'S MAIDEN NAME First Lanna	Middle Poland	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) None	17. INFORMANT P.O. Box 599, Allegany County Infirmary records.	Address Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 41-29 Arteriosclerotic heart disease Chronic bronchitis Arteriosclerosis Arteriosclerosis							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx. 2 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Exacerbated B.S. with intestinal deterioration							
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None	20a. AUTOPSY? NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) None					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC None	21f. LOCATION Street or RFD No None	City or Town None	County None	State None		
22a. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1968 to Dec. 24, 1968 , that (I) (we) last saw the deceased alive on Dec. 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, () (we) (did) (did not) view the body after death							
22b. SIGNATURE George A. Tepper	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-28-68			
22d. PHYSICIAN'S NAME (Type) George A. Tepper	22e. ADDRESS Memorial Hospital, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/28/68	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland	(County) A.	(State) Md.		
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR DEC 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16708

16721

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First CORA	Middle M.	Last DAVIS	2d. DATE OF DEATH Month Dec Day 9 Year 1968	2b. HOUR 6:05A	
3. SEX FEMALE	4 RACE WHITE			S. DATE OF BIRTH 08-06-1986	6. AGE (In years last birthday) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ALLEGANY			
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of time) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MD.	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT. 4 BOX 218			
14. FATHER'S NAME First CHARLES	Middle HOUSE	Last	15. MOTHER'S MAIDEN NAME First RUTH	Middle E.	Last PIPER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 220-18-9359-11	17. INFORMANT MEMORIAL HOSP., CUMBERLAND, MD.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Viral Influenza DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency (c) Arteriosclerotic Cardiovascular Disease years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) +201 Chronic Atrial Fibrillation							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19, to Dec. 9 , 19 68 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Dec. 9 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 	22c. DEGREE ATTENDING PHYS	22d. MED. DIRECTOR <input type="checkbox"/>	22e. STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-9-68			
22d. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT M.D.	22e. ADDRESS 133 VA. AVE., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC 11 1968	23c. NAME OF CEMETERY OR CREMATORIAL DAVIS MEMORIAL CEMETERY	23d. LOCATION (City or Town) RTD# 4 CUMBERLAND ALLEGANY MD.	(County)	(State)		
24. FUNERAL DIRECTOR H. LEE SILCOX	ADDRESS 404 DEGATUR ST CUMBERLAND MD.	25a. REC'D BY REGISTRAR DEC 12 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

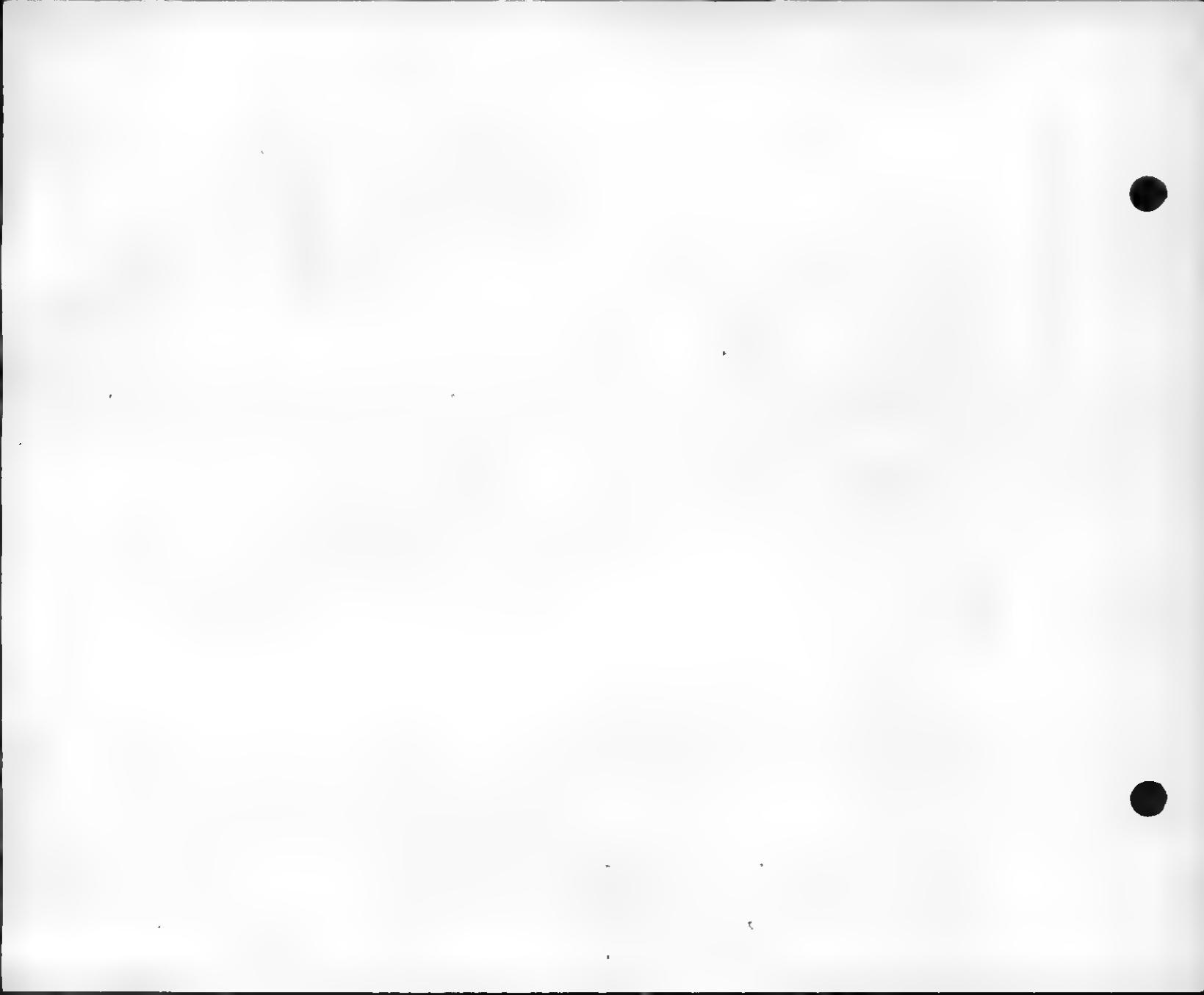
CERTIFICATE OF DEATH

16722

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove from all papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED NAME (Type or print)		First DELLA	Middle W.	Last DAVIS	2a. DATE OF DEATH Month DEC.	Day 3	Year 1968	2b. HOUR 9 A M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 7, 1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.		
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN ALLEGANY		13c. CITY OR TOWN VALE SUMMIT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First JOHN		Middle S.	Last CARR	15. MOTHER'S MAIDEN NAME First ELIZABETH		Middle 	Last MATTHEWS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT LLOYD F. DAVIS, RT. 1, FROSTBURG, MD. 21532		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF age								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>77</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20, 1968</u> , to <u>12/13, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John B Davis</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED <i>12/15/68</i>		
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22e. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532								
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE DEC. 6, 1968		23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK		23d. LOCATION (City or Town) FROSTBURG, MD.		(County) (State)		
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.		ADDRESS 		25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



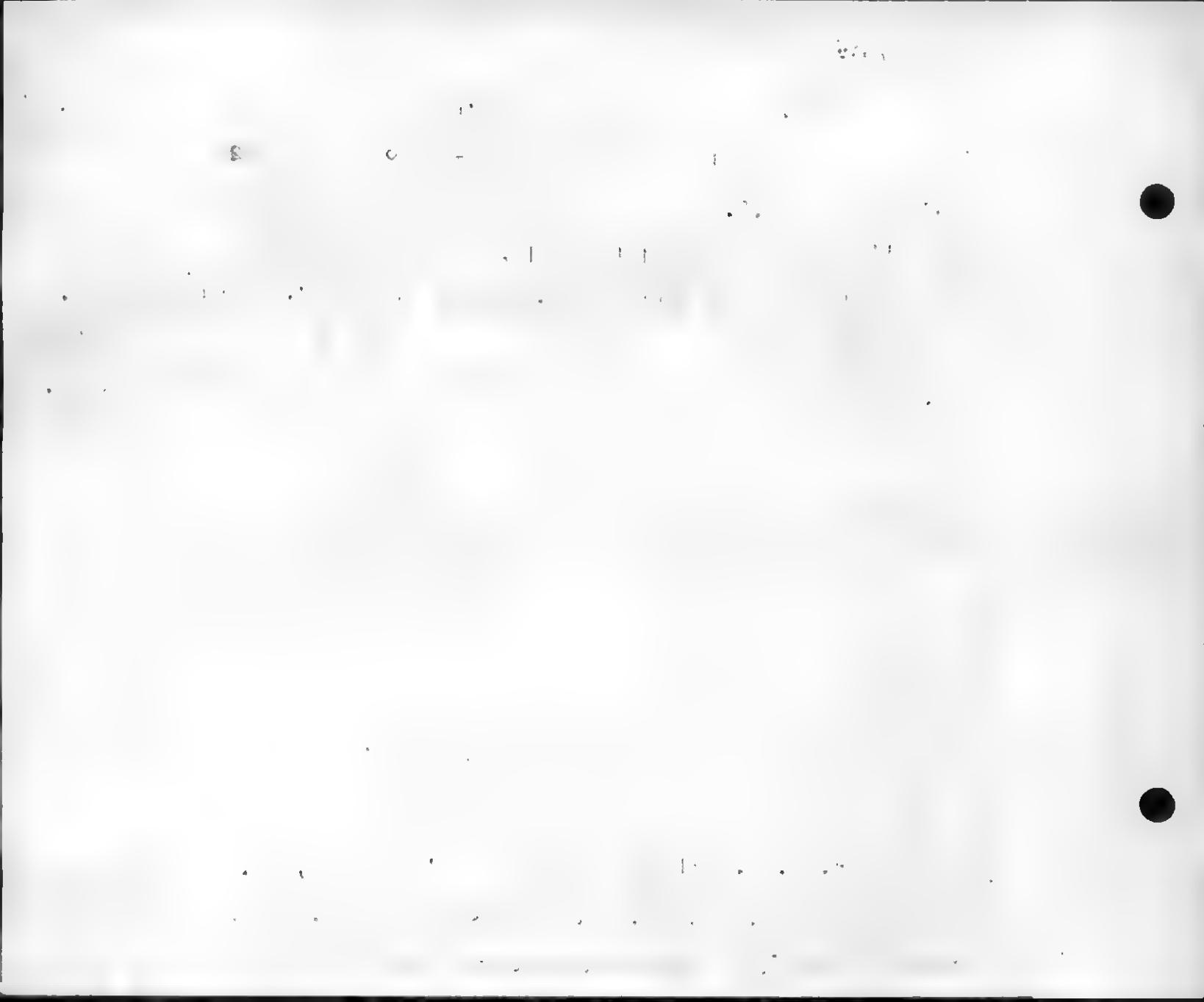
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16723

16710
16710

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove your papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First DOROTHY	Middle P	Last DAVIS	2a DATE OF DEATH Month 12	Day 5	Year 68	2b. HOUR P 12:45 M
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH 4-27-06			6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		Md
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 315 SPRINGDALE ST.			
14. FATHER'S NAME First JAMES	Middle GORDON	15. MOTHER'S MAIDEN NAME First MOLLIE			Middle 	Lost MORGAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Heart Disease - Rheumatic and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF 2 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10/18 , 1968, to 12/5 , 1968, that (I) (we) last saw the deceased alive on 12/5 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>H. Weismann</i>		DEGREE DR.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12/16/68		
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 8, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Savage Methodist Cem		23d. LOCATION (City or Town) Mt. Savage	(County) Alleg	(State) Md		
24. FUNERAL DIRECTOR <i>Charles E. Hafer</i>	ADDRESS 230 Belto Ave. Cumberland			25a. REC'D BY REGISTRAR DEC 10 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 30M REV. 1/68								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

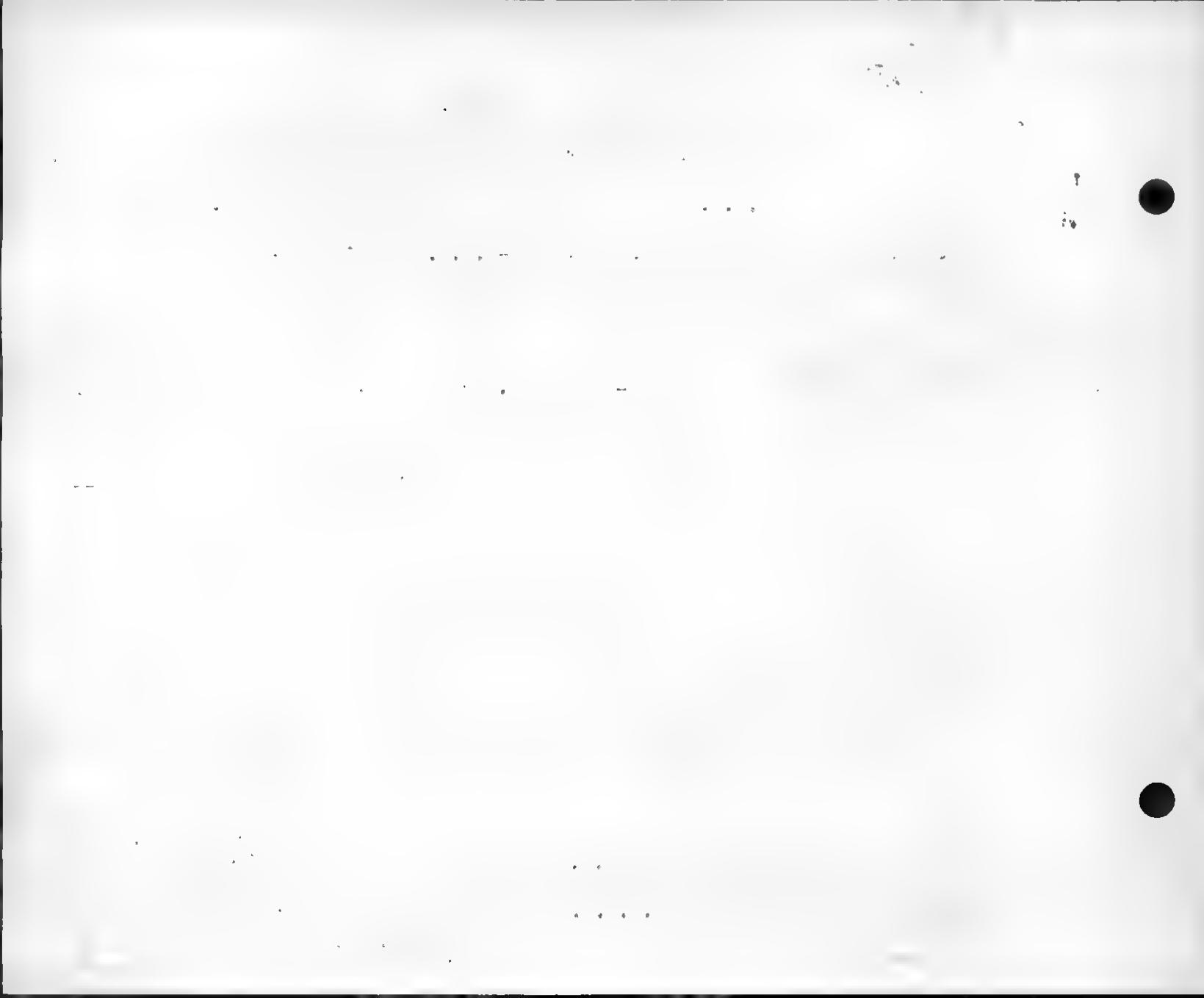
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16724

1. DECEASED NAME (Type or Print)		First John	Middle Joseph	Last Donahoe	20. DATE KNOWN OF ESTI- MATED DEATH Month 12	Doy 15	Year 1968	20 HOUR P 6:50M				
3 SEX Male	4 RACE White	5 DATE OF BIRTH October 27-1990	6 AGE (In years last birthday) 68 yrs	IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 12			2d HOUR Doy 15	Year 1968	2d HOUR P 6:50M		
7a BIRTHPLACE (State or foreign country) Penns.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Allegany			Md			
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-D.O.A.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE Maryland		13b. COUNTY Allegany		13c CITY OR TOWN Flintstone	13d. INSIDE CTY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER						
14. FATHER'S NAME William		Middle Donahoe	Last Donahoe	15. MOTHER'S MAIDEN NAME Anna	Middle Drenning	Last Drenning						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO WW II		17. INFORMANT Mrs. Vera Turner					ADDRESS RFD #2 Flintstone, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED December 15, 1968				
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/19/68		23c NAME OF CEMETERY OR CREMATORIAL I.O.O.F. Cemetery		23d LOCATION (City or Town) Flintstone		(County) Allegany		(State) Maryland		
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service		ADDRESS Cumberland, Md			25a REC'D. BY REGISTRAR DEC 18 1968		25b REGISTRAR'S S.G.NAT.RE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. That please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First May	Middle I.	Lost Dugan	20 DATE OF DEATH at 6:20 P.M. Month December 23, 1968 Year	2b. HOUR P. M.	
3. SEX Female		4. RACE White		S. DATE OF BIRTH 5/29/1880	6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany County		
10. CITY OR TOWN OF DEATH Cumberland Allegany County Infirmary		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Housewife		12a. USUAL OCCUPAT. ON (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased resided, if institution, Reside before admission) STATE Maryland		13c. CITY OR TOWN Allegany Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 510 Pearre Avenue		
14. FATHER'S NAME First George		Middle Keedy	15. MOTHER'S MAIDEN NAME First Alice	Middle		Lost Jorden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO 214-01-3632D		17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Addressee Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina pectoris</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(c) <u>Chronic HD with hypertension</u>		<u>many years</u>		<u>many years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic cholelithiasis with Cholelithiasis.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 18, 1968</u> , to <u>Dec. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John A. Keppler</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>12-24-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>John A. Keppler</u>		22e. ADDRESS Memorial Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE Dec. 26, 1968	23c. NAME OF CEMETERY OR CREMATORIUM FBG. MEMORIAL PARK		23d. LOCATION (City or Town) FROSTBURG, MD.	(County)	(State)
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG,		ADDRESS MD. 21532	25a. RECD BY REGISTRAR DATE <u>DEC 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

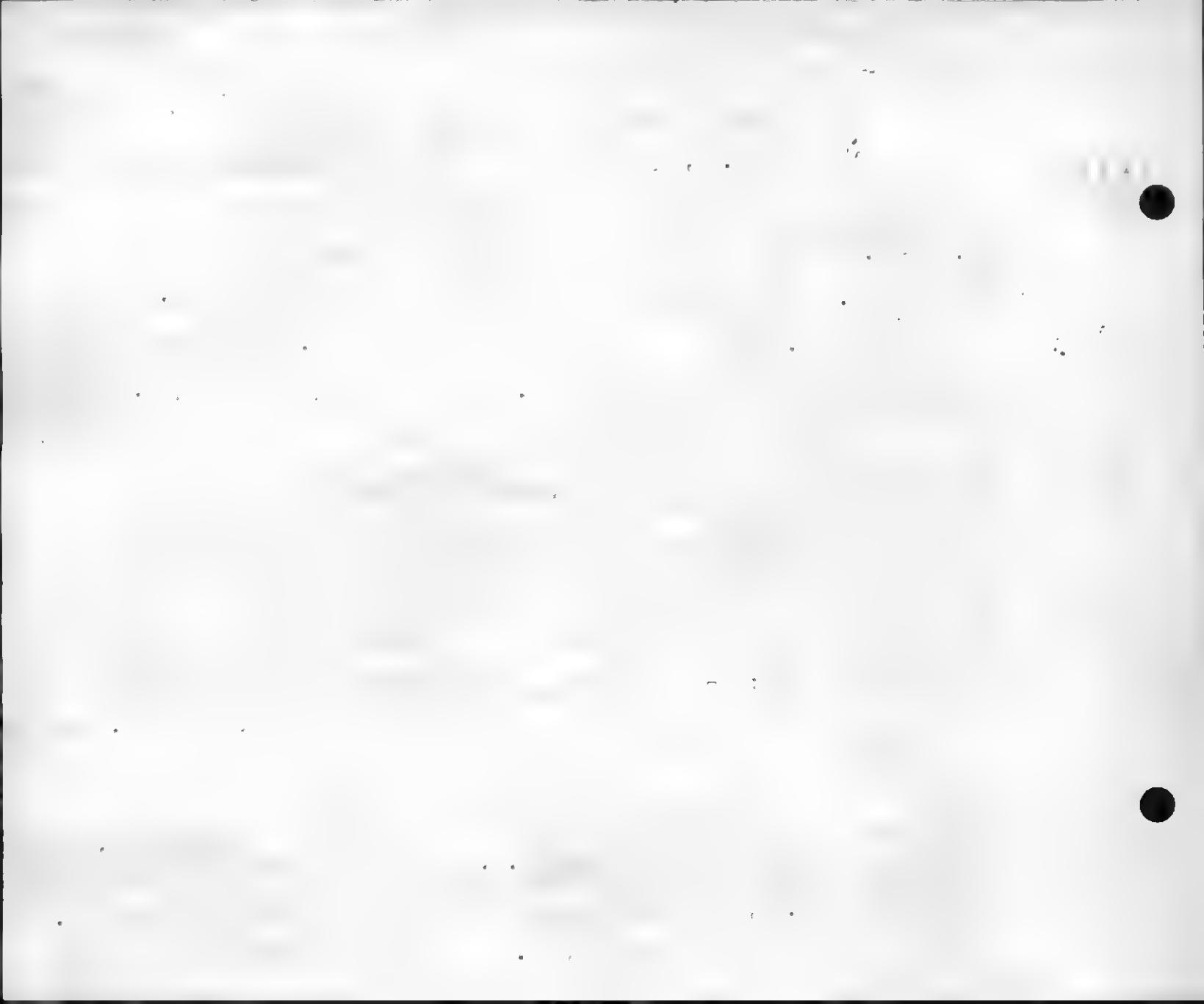
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certifcate, writing the word "pending" in pencil in Item 8. Give Page 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16726

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED	Month Day Year	2b HOUR
			Francis Henry Durbin			<input checked="" type="checkbox"/>	Dec. 20, 1968	12:40 AM
3 SEX	4 RACE	S. DATE OF BIRTH	5 AGE (In years last birthday)	F UNDER 1 YEAR	F UNDER 24 HRS			
Male	White	Dec. 29, 1950	17 YRS	MONTHS	DAYS	HOURS	MIN	
7a BIRTHPLACE (State or foreign country)	7b CIT.ZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	American					Allegany		
10 CITY OR TOWN OF DEATH Rt. 220-Mi. North	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY					
	Memorial Hospital	Attendant	Gas Station					
13a USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) STATE	13c CITY OR TOWN	13d INSIDE CITY - MTS?	13e STREET AND NUMBER					
Md.	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 65 Offutt St.					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
William R. Durbin				Augusta A. Haenftling				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS					
no	(If yes give war or dates of service)	Mr. Douglas Durbin, Cumberland, Md.-Brother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
8191 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.				2 Hours				
(b)				Ruptured Aorta				
DUE TO, OR AS A CONSEQUENCE OF								
(c)				(Automobile Accident)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a EXTERNAL CAUSE WAS PR MARYS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State				
		Route # 220		One mile North Cumberland, Allegany, Maryland				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 20, 1968 ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (If applicable)		23b DATE	23c NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d LOCATION (City or Town) (County) (State)			
Burial		Dec. 22, 1968			Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR		ADDRESS	25a REC'D BY REGISTRAR DEC 26 1968	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
		James F. Scarpelli, Cumberland, Md.						



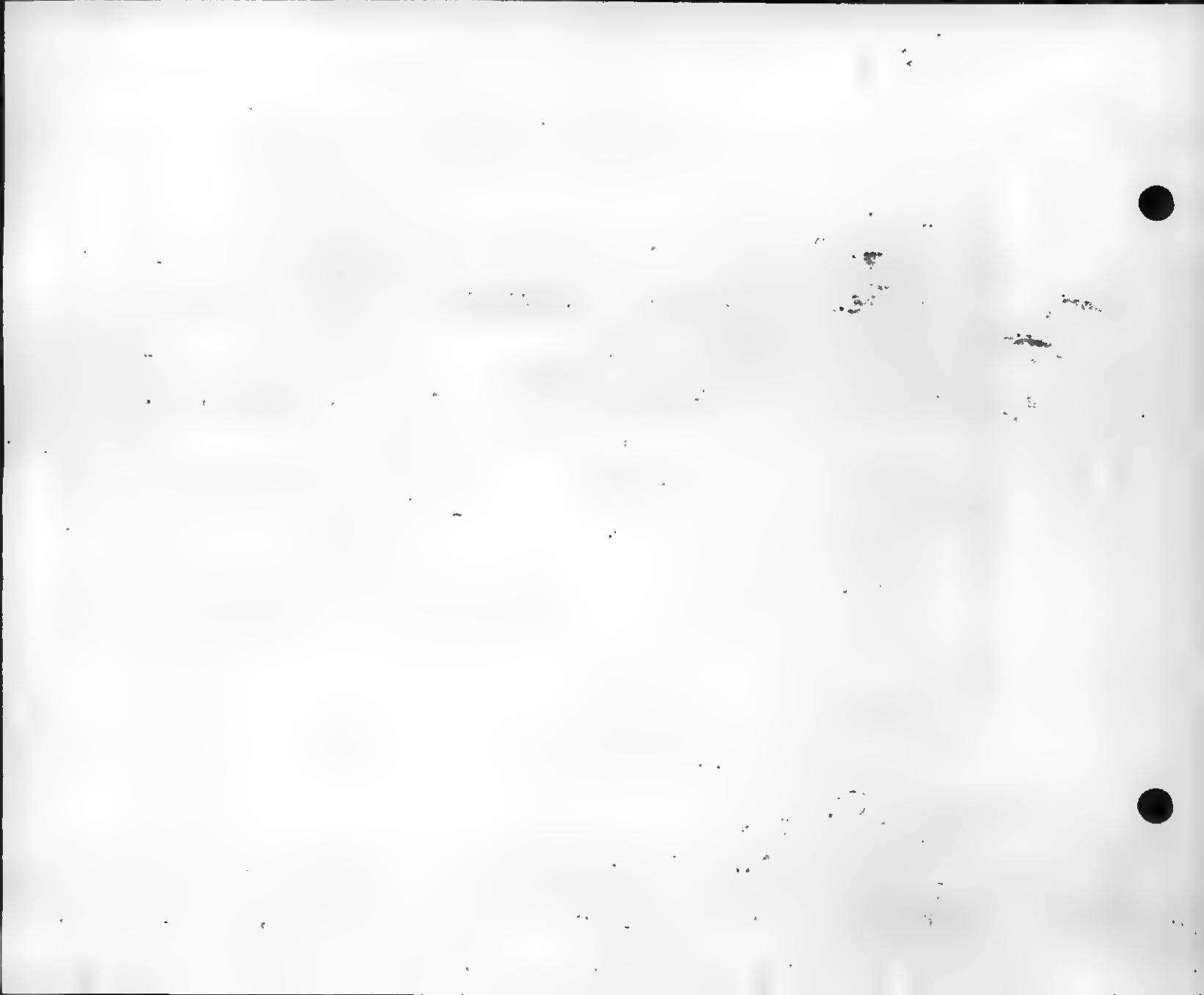
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Ruth	Middle Mae	Lost Durst	2a. DATE OF DEATH Month December	Day 12, 1968	Year 1968	2b. HOUR Hr.		
3. SEX <input checked="" type="checkbox"/> F		4. RACE <input type="checkbox"/> W		S. DATE OF BIRTH Feb. 8, 1900	6. AGE (In years last birthday) 68		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 MRS HOURS DAYS	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miner's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13b. CITY OR TOWN Allegany		13c. CITY OR TOWN Midland	13d. INSIDE CITY, MTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER Lonaconing				
14. FATHER'S NAME First Edward		Middle Durst	Lost	15. MOTHER'S MAIDEN NAME Charlotte		Middle Cramer		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> No		16b. SOCIAL SECURITY NO. 212-54-8334		17. INFORMANT Sherman Durst, Midland, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		4409 Cardiac Arrest		DUE TO, OR AS A CONSEQUENCE OF (b) Intractable Congestive Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis		10 wks years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Urinary										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>Dec. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 		M.D. DEGREE		ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-12-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS LONACONING, MD 21539								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/68		23c. NAME OF CEMETERY OR CREMATORIAL Springs Cemetery		23d. LOCATION (City or Town) Springs, Somerset, Pa.		(County) (State)		
24. FUNERAL DIRECTOR Kurt Neumann		ADDRESS Grantsville, Md.		25a. REC'D. BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL, **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed in 24 hours after death. Page 4, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16715		16728	
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If out's da corporate limits, write RURAL and give nearest town) Westernport		2. USUAL RESIDENCE (Where deceased lived, If institutions Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If out's da corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 404 Walnut St.		d. STREET ADDRESS 404 Walnut St.	
3. NAME OF DECEASED (Type or print) Donald W. Fairall First Middle Last		4. DATE OF DEATH Dec. 11 1968	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 20 years Army		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County, state, or country) Westernport, Md		9. AGE (In years, month, day) IF UNDER 1 YEAR Months Days Hours Min. 53 yrs.	
13. FATHER'S NAME Walter Fairall		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) Yes 1942 - 1962		16. SOCIAL SECURITY NO. 17. INFORMANT 217-05-0351 Mary Margaret Kolberg Piedmont, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address 79 W. Hampshire INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5119 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Hypoproteinemia DUE TO (c) Chrosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from to saw the deceased alive on and that death occurred at from the causes and on the date stated above.		22a. SIGNATURE Robert W. Bess Jr.	
22c. PHYSICIAN'S NAME (Type) Robert W. Bess Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 122 Ashfield St., Piedmont, W.Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-68	
24. FUNERAL DIRECTOR'S SIGNATURE W. Harold Fredlock, Jr.		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat.	
		23d. LOCATION (City, town or county) Arlington, Va.	
		25a. REC'D BY REGISTRAR DATE DEC 16 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

as

Attribution

Attribution Mat

86-16-21

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

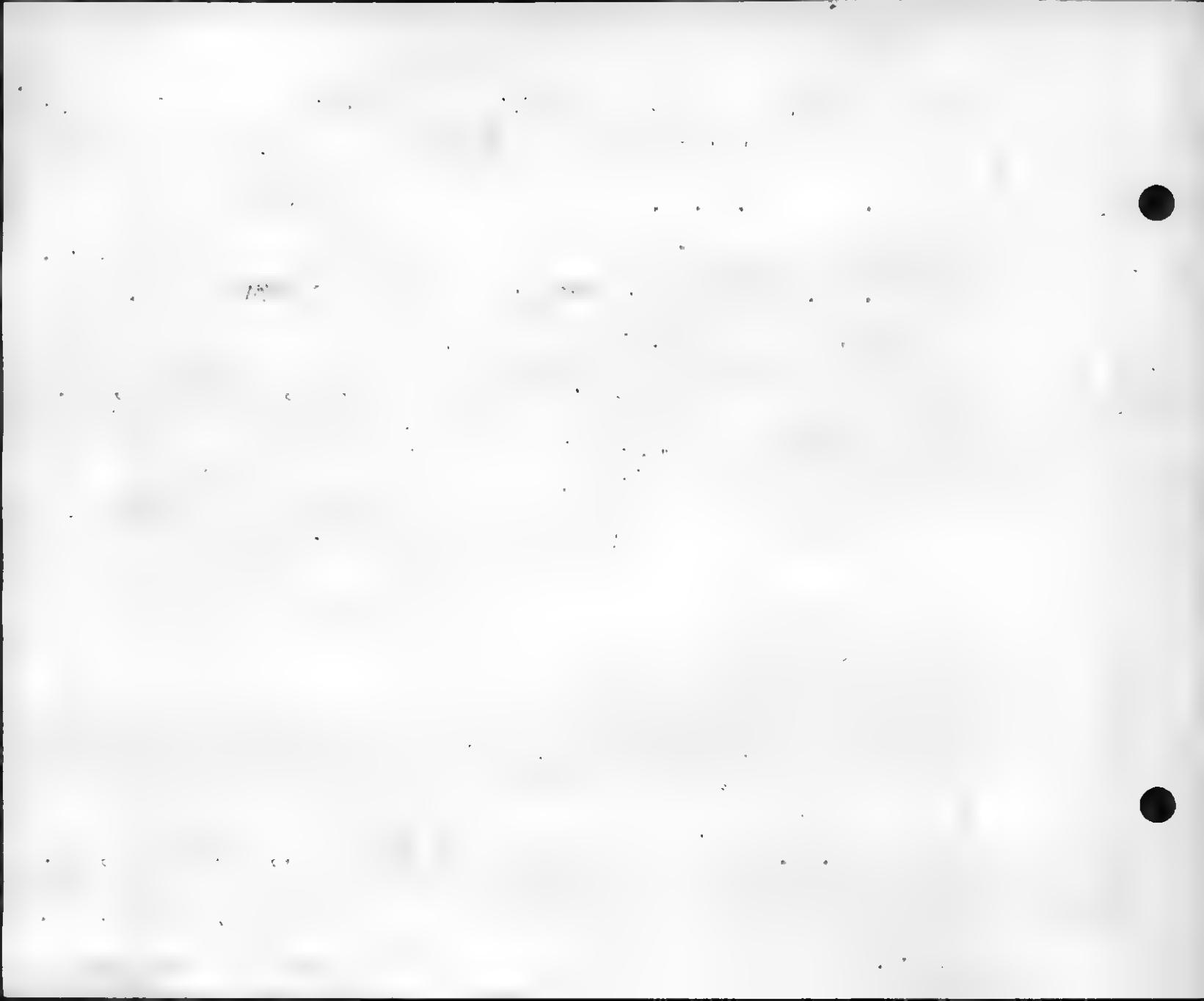
16729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (Type or print)	First WILLIAM	Middle --	Last FOSTER	2a. DATE OF DEATH DEC Month 15 Day 1968	2b. AM. 12:35
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 3/27/1880	6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) PENNA.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital given above) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Steel Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE W. VA.	13c. CITY OR TOWN RIDGELEY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15 WA-BASH ST.		
14. FATHER'S NAME PATRICK	First MIDDLE FOSTER	15. MOTHER'S MAIDEN NAME MARY	MIDDLE KRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	16b. SOCIAL SECURITY NO. 162-18-5379	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address 300 N. Main Street, Cumberland, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Chronic Nephritis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Nephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Nephritis</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1968</i> , to <i>Dec 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. Schindler</i>	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>Dec 15, 1968</i>		
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER	22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE 12/17/68	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park,	23d. LOCATION (City or Town) Cumberland, Allegany Md.	(County)	(State)
24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Maryland	25a. REC'D BY REGISTRAR DEC 20 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

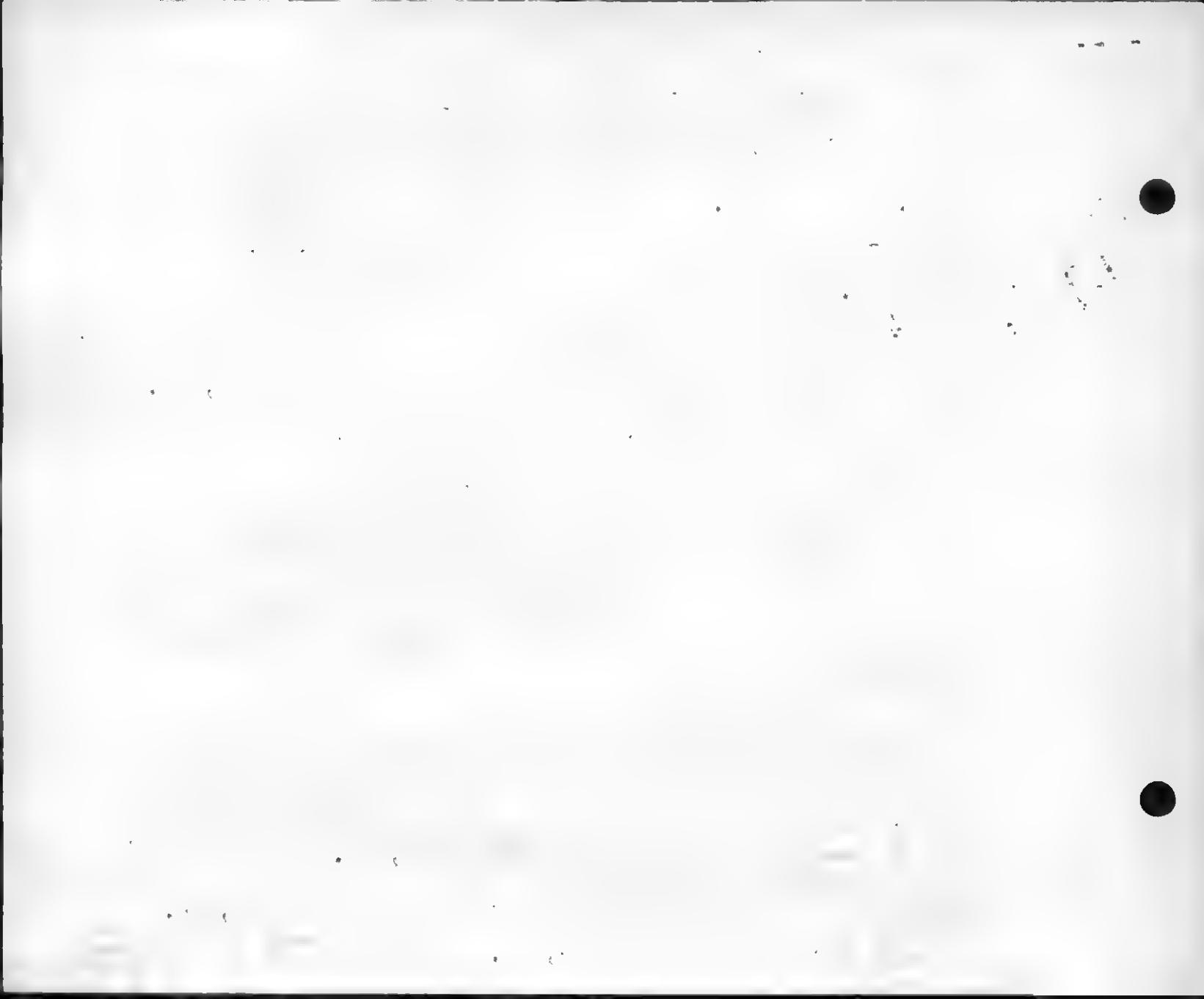
TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16730

1. DECEASED NAME (Type or Print)		First Bessie	Middle Victoria	Last Foutz	20 DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 12/19/68	2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH 2/18/1906	6 AGE (In years month) 62 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month Day Year 12/19/1968 19	2d HOUR M
7a BIRTHPLACE (State or foreign country) MD.	7b CITIZEN OF WHAT COUNTRY? USA.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Allegany	Md		
10. CITY OR TOWN OF DEATH Gilmore-Rural		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital gave street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. JURISDICTION (Where deceased lived, if institution residence before admission) STATE MD.		13b. COUNTY Allegany	13c. CITY OR TOWN Gilmore	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER	
14. FATHER'S NAME First William		Middle Van	Last Buskirk	15. MOTHER'S MAIDEN NAME First Laura	Middle Clise	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) None		17. INFORMANT William Foutz, Gilmore, Md.	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Tosis Generalized 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of right breast DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 18X						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 12/19/1968
EXAMINER'S NAME (Type) Benedict Skitarelic		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cumberland, Md., or county				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/23/1968	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow, Md.	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.	25a. RECEIVED BY REGISTRAR DATE DEC 24 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16718

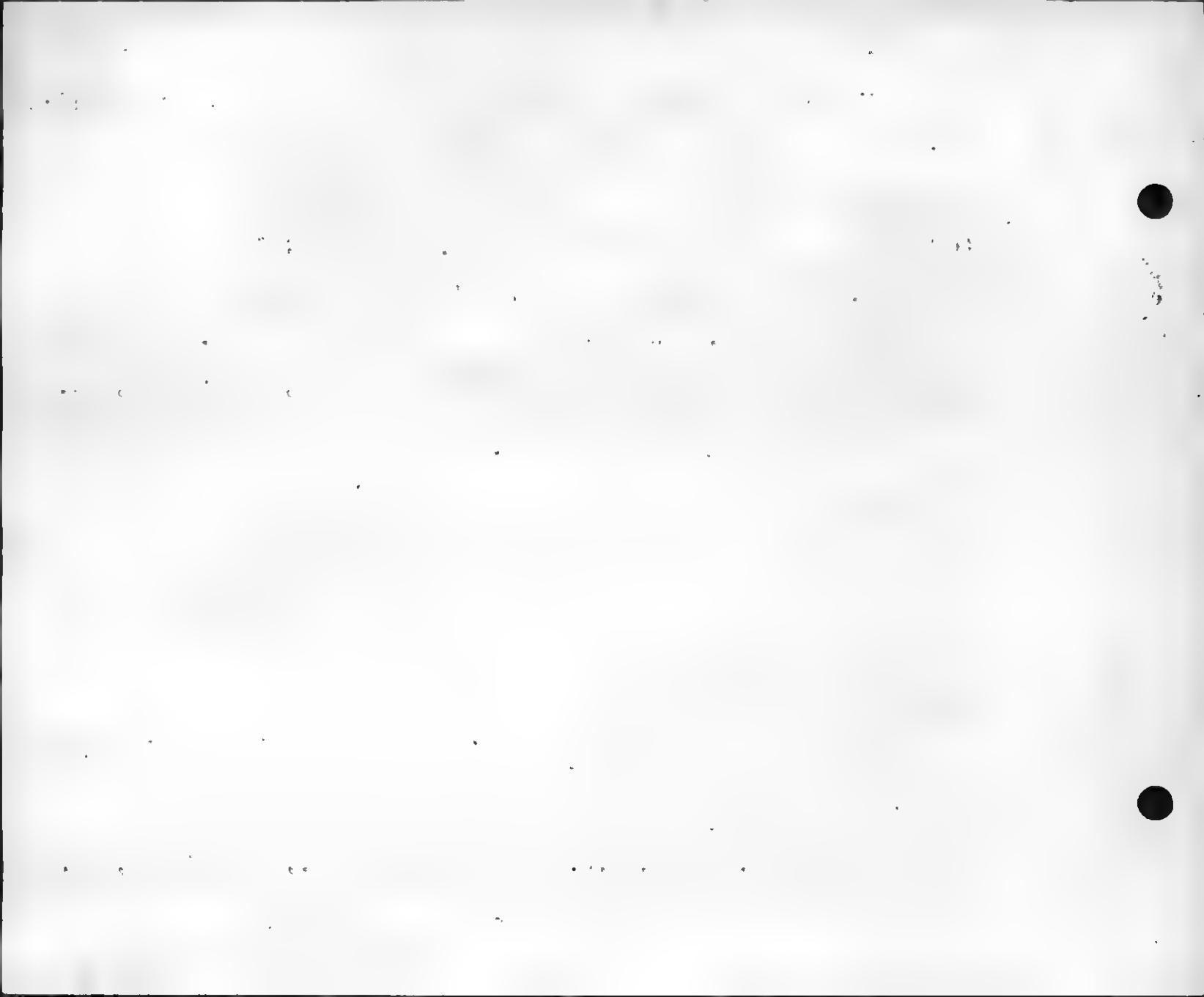
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16731

Item FilmG407 12/18/68 kk

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First MARGARET	Middle ANNA	Last GOERG	2d. DATE OF DEATH 12 Month 5 Day 68 Year	2b. HOUR 12:45
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 9/30/13	6. AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most recent year if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY GARRETT	13c. CITY OR TOWN ACCIDENT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First ADAM	Middle J.	Last RICHTER	15. MOTHER'S MAIDEN NAME, First HELEN	Middle M.	Last SAUERWALK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cannimatosis - DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause 18.30 (b) Primary in ovary - DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of ovary	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19., to 12/4 , 19 68 , that (I) (we) last saw the deceased alive on Dec 4 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas F. Lewis M.D.</i>		22c. DATE SIGNED 12/6/68			
22d. PHYSICIAN'S NAME (Type) THOMAS F. LEWIS, M.D.		22e. ADDRESS 500 GREEN ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Zion Tuth. Church Cem. Accident, Garrett, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Kurt Neumann	ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV 1/68					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

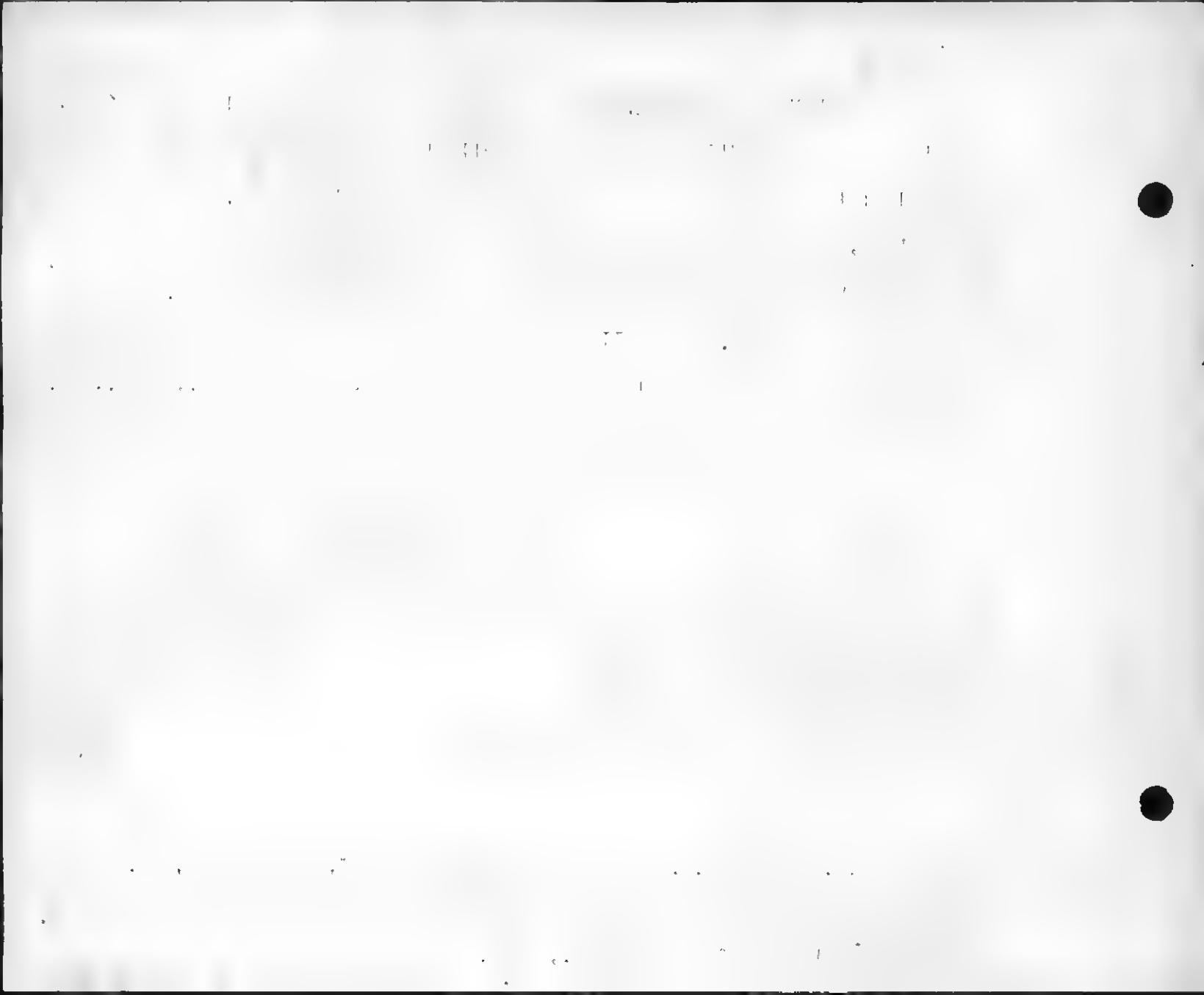
CERTIFICATE OF DEATH

16732

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-tranit permit. It should be filed with the State Dept. of Health prior to burial, cremation, or removal. Open in any event, with in 72 hours after death.

1 DECEASED NAME (Type or print)		First RUBY	Middle PAULINE	Last GRAHAM	20 DATE OF DEATH Month 12 Day 25 Year 68	26 HOUR 7:18AM	
3 SEX FEMALE		4. RACE WHITE		S DATE OF BIRTH 7-11-81	6 AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY CO.		Md.
10 CITY OR TOWN OF DEATH CUMBERLAND,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. list give address and names)		12a. U.S. OCCUPATION (Kind of work done during most of work life, even if retired) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own home.	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 842 GREENE ST.	
14 FATHER'S NAME First AMOS		Middle S.	Last ARNETT	15 MOTHER'S MAIDEN NAME First HARRIET	Middle	Last CONWAY	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16b SOCIA. SECURITY NO 214-10-5342		17 INFORMANT HOSPITAL RECORD, 900 SETON DR., CUMB., MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221		<i>Central Infarction - cerebral thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
(b)		DUE TO, OR AS A CONSEQUENCE OF		<i>Arterosclerotic cardiovascular disease</i>		104	
(c)				<i>and Cerebral arterosclerosis</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hiatus Hernia Arterosclerotic Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No.	City or Town	County	State	
22a. I certify that (1) (this hospital) attended the deceased from Sept. 19, 67 , to 25 Dec. 19, 68 , that (1) (we) last saw the deceased alive on 12/24/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Al Weisman</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12/25/68	
22d. PHYSICIAN'S NAME (Type) S.G. WEISMAN M.D.		22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/28/68	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park,		23d. LOCATION (City or Town) Cumberland, Allegany Md.	(County)	(State)
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS GEORGES FUNERAL HOME, 202 GREENE ST., CUMB.	25a. RECD BY REGISTRAR DATE DEC 31 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be removed from the burial permit. Then please remove carbon paper, page 3 should be detached for use as the burial permit. Then please remove carbon paper, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 It em#13eFilm#G408 12/31/68 vmp CERTIFICATE OF DEATH

16733

1. DECEASED NAME (Type or print)	First EARL	Middle W.	Lost GROWDEN	2d. DATE OF DEATH Month 18 Day 68 Year	2b. HOUR M
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 03-04-12	6. AGE (In years last birthday) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give address) MEMORIAL HOSPITAL	12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired.) ELEVATOR OPERATOR	12b. KIND OF BUSINESS OR INDUSTRY TIRE IND.		
13a. USJAL RESIDENCE (Where deceased lived, if inst lation Residence before admission) STATE MD.	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT. 3 BEDFORD ROAD	
14. FATHER'S NAME ESBY	First Middle GROWDEN	15. MOTHER'S MAIDEN NAME First LILLIE	Middle HARDINGER	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 174 16 8382	17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 486 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 174 (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cystitis & Prostatitis Rheumatoid arthritis					
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1948 to 12/18, 1968, that (I) (we) last saw the deceased alive on 12/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Weisman	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.	22e. ADDRESS 59 GREEN ST. CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 21, 1968	23c. NAME OF CEMETERY OR CREMATORY FELLOWSHIP CEMETERY	23d. LOCATION (City or Town) CENTERVILLE, PA.	(County)	(State)
24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD	25d. REC'D BY REGISTRAR DEC 24 1968	25e. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16734

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Carter	Middle McNeil	Lost Harness	2d. DATE OF DEATH Month Dec. Day 15 Year 1968	2b. HOUR 4:30M		
3. SEX Male	4 RACE White	5. DATE OF BIRTH July 20, 1906		6. AGE (in years last birthday) 62 YRS.	IF UNDERR MONTHS 0	YEAR 0	IF UNDERR 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired). Retired Truck Driver-Textile		12b. KIND OF BUSINESS OR INDUSTRY Textile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.		13b. COUNTY Mineral	13c. CITY OR TOWN Ridgeley	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 12 Second Ave.			
14. FATHER'S NAME First George		Middle S.	Lost Harness	15. MOTHER'S MAIDEN NAME First Catherine	Middle Plauger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 214-07-1013		17. INFORMANT Daughter	Address Miss Patricia Harness, Ridgeley, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs				
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause due to, or as a consequence of		(b) DUE TO, OR AS A CONSEQUENCE OF						
		(c) DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. Frank Williams	City or Town Ridgeley, Md.	County Allegany	State Md.	
22a. I certify that (I) (this hospital) attended the deceased from 4/13/68 , 19, to 4/17/68 , 19, that (I) (we) last saw the deceased alive on 4/16/68 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard J. Williams		22c. DATE SIGNED Dec. 17, 1968						
22d. PHYSICIAN'S NAME (Type) Dr. Richard J. Williams		22e. ADDRESS 122 S. Centre St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 18, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge			
				DATE DEC 20 1968				



4
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16735

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon loppers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Annie	Middle Elizabeth	Last Hartell	2d DATE OF DEATH Month Dec. Month 8 Year 1968	2b HOUR 4: P M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Dee. 26, 1876		6 AGE (in years at birthday) 91	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Allegany	Md.		
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 121 Springdale St.		12a USUAL OCCUPATION (Kind of work done during master of working life even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 121 Springdale St.	
14. FATHER'S NAME First John Snyder	Middle Last	15. MOTHER'S MAIDEN NAME First Middle Sarah Shank		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT Mr. Frank W. Hartell, Cumberland, Md.-Son	Address 3 mrs		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decommatosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mon		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Carcinoma Cervix		10 mon		
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Decompensation				3 wks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Jan 1968 , to Dec 5, 1968 , that (I) (we) last saw the deceased alive on Dec 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Clay E. Durrett		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Dec. 9, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, MD		22e. ADDRESS 236 Virginia Ave., Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Cumberland Allegany, Md.	(County)	(State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.	25a. RECEIVED BY REGISTRAR DEC 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE	
VR A15 30M REV. 1/64						



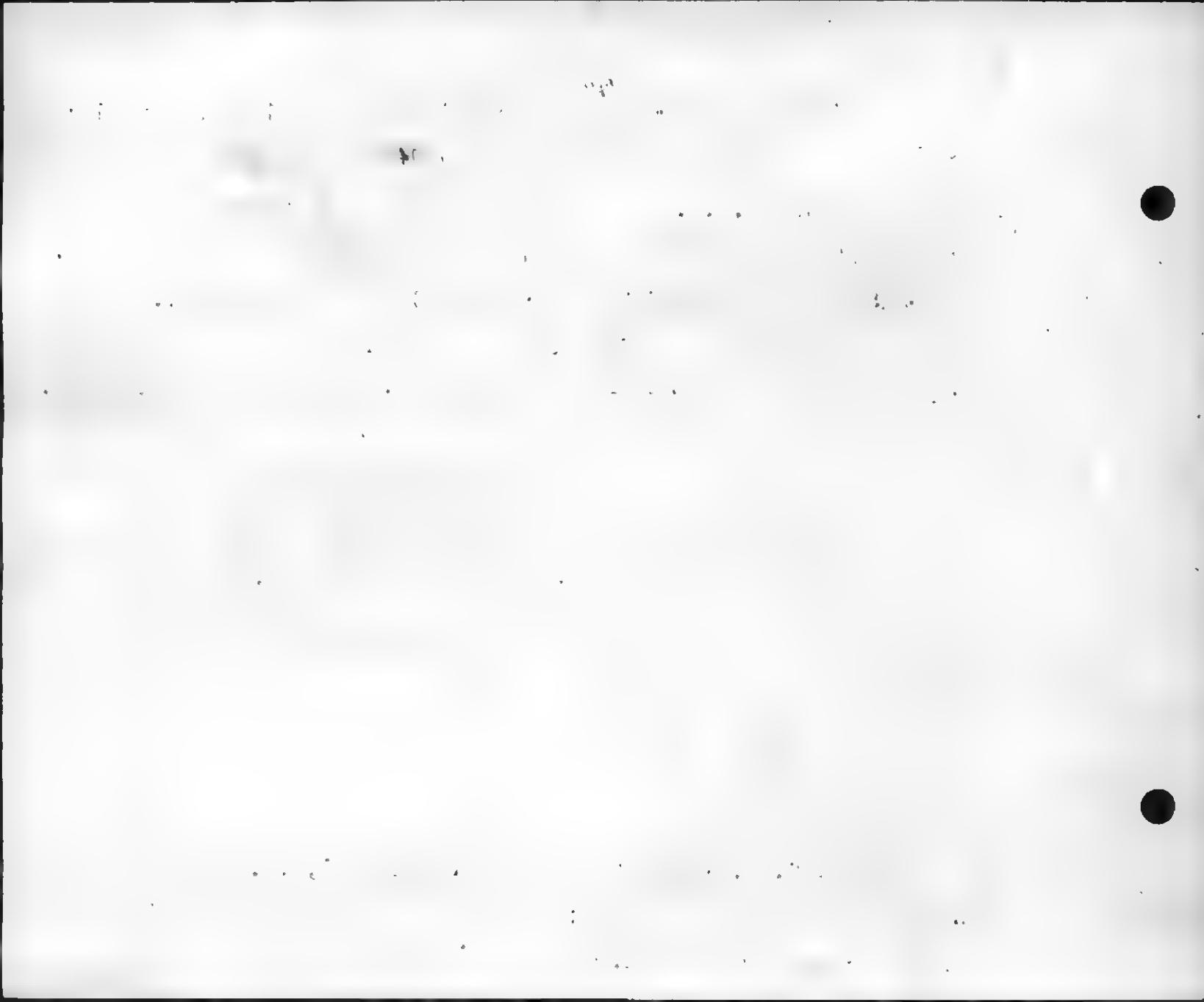
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16736

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First THOMAS	Middle KINNEY	Last HASTINGS	2a. DATE OF DEATH Month 12	Day 25	Year 68	2b. HOUR 11:40AM		
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 12-7-64	6. AGE (in years last birthday) 84 YRS.	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF UNDER 24 HRS. HOURS 0	10. IF UNDER 24 HRS. MIN 0		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY						
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during working life, even if retired) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Mens Clothing						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 149 POLK ST.					
14. FATHER'S NAME First JAMES	Middle HASTINGS	15. MOTHER'S MAIDEN NAME First MOLLIE	Middle KELLER	Lost 0					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No	16b. SOCIAL SECURITY NO 214-07-1094	17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.	Approximate Interval Between Onset and Death 2 yrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of sigmoid colon with metastases to bladder and retroperitoneal tissues</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>1533</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								Approximate Interval Between Onset and Death 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Pulmonary TB - arrested</i>								<i>arteriosclerotic cardiovascular disease</i>	
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <i>60</i> , to _____, 19 <i>68</i> , that (I) (we) last saw the deceased alive on _____, 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alvessuer</i>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12/25/68</i>							
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN	22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/28/68	23c. NAME OF CEMETERY OR CREMATORIAL Circle Hill Cemetery,	23d. LOCATION (City or Town) (County) Punxsutawney, Jefferson, Penna						
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland,	ADDRESS Md.	25a. REC'D. BY REGISTRAR DEC 31 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



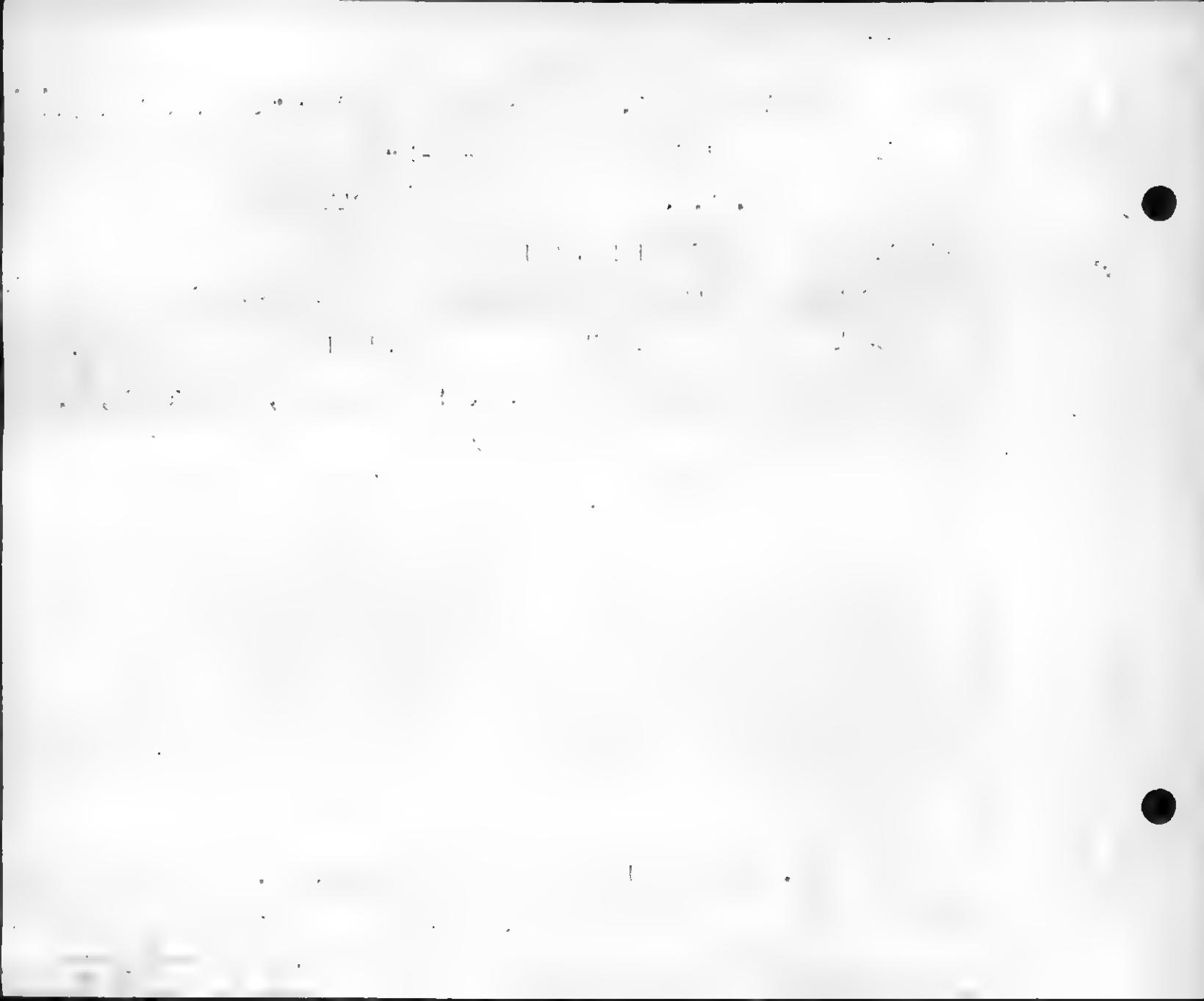
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16737

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First ALBERT	Middle F.	Last HENKEL	20 DATE OF DEATH DECEMBER 13, 1968	2b HOUR M. 5:15M	
3. SEX MALE		4 RACE WHITE	5 DATE OF BIRTH 3-20-1902		6. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ALLEGANY		
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving name) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trucker		12b. KIND OF BUSINESS OR INDUSTRY Rail Road	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Cumberland, Md. Winchester Rd.	
14. FATHER'S NAME First CARL		Middle HENKEL	15. MOTHER'S MAIDEN NAME First CHRISTINA		Middle QUANTZ	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-05-9207		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129		DUE TO, OR AS A CONSEQUENCE OF (b) ischaemic heart disease		CVA DUE TO, OR AS A CONSEQUENCE OF (c) loss of circulation to brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1968 , to Dec 13, 1968 , that (I) (we) last saw the deceased alive on Dec 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Blane Schindler</i>		DEGREE DR.	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12/17/68			
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/68	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d. LOCATION (City or Town) Cumberland, Allegany Md.	(County) (State)	
24. FUNERAL DIRECTOR William G. Kight		ADDRESS Cumberland, Md.	25a. RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

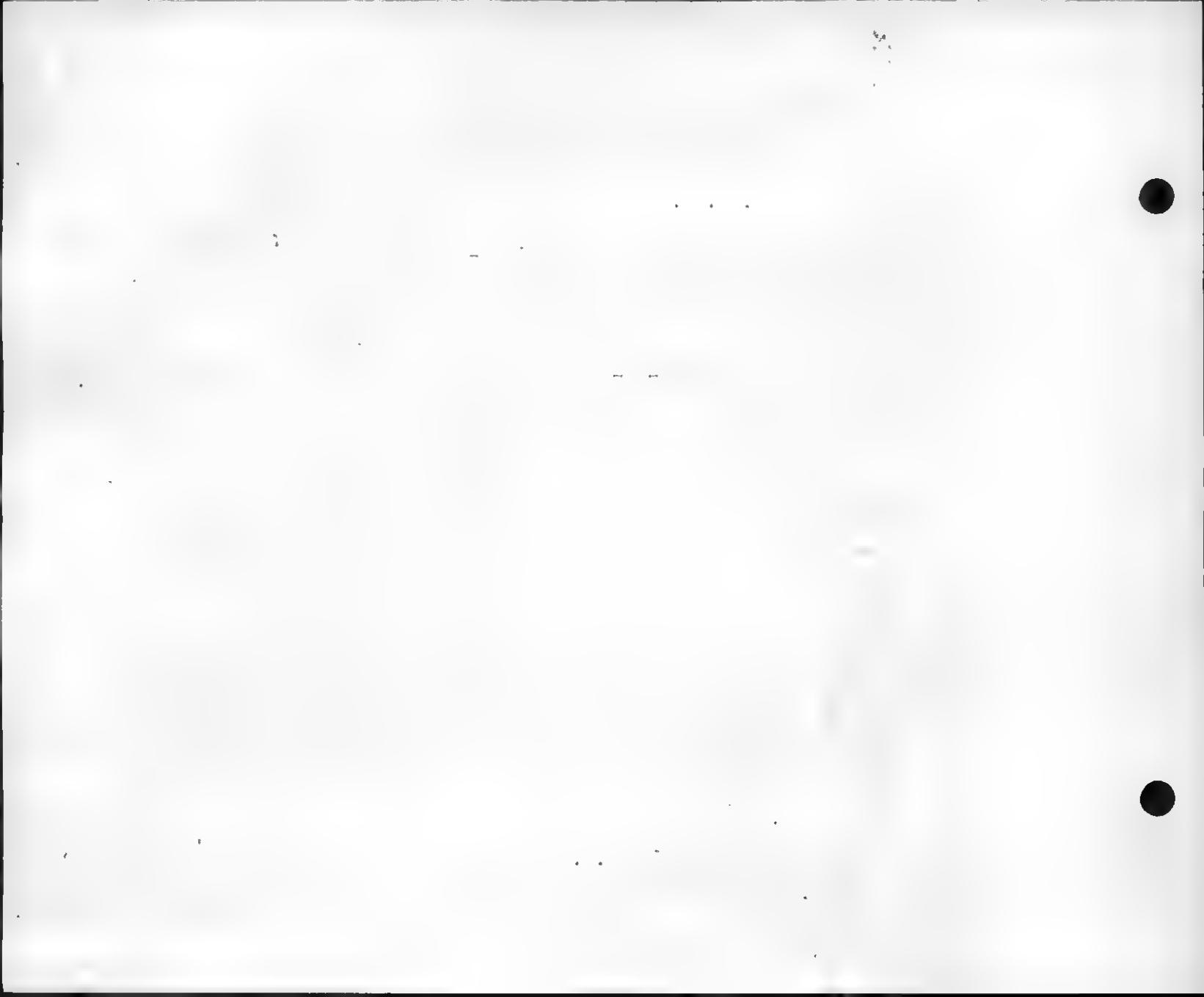
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16725 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16738

1 DECEASED NAME (Type or Print)		First ALICE	Middle J. MILDRED	Last HERATH	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> DEC 3 1968	2b HOUR 1:45 pm		
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MAY 23, 1901	6 AGE (in years last birthday) 67 YRS	F UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS DAYS <input type="checkbox"/>	MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Day Year DEC 3 1968	2d HOUR 1:45 pm
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY			
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital-DOA			12a USUAL OCCUPATION (Kind of work done or kind of business or profession) PART-TIME EMPLOYEE ROSEWOOD STATE		12b KIND OF BUSINESS OR PROFESSION HOSPITAL	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY & LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 217 GLENN STREET		
14. FATHER'S NAME First AMOS		Middle GROSS	Last	15. MOTHER'S MAIDEN NAME First VICTORIA		Middle	Last BOWMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-24-1260a		17. INFORMANT WALTER P. DENNISON		ADDRESS 400 BEDFORD ST. CUMBERLAND		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a). _____</p> <p>(b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>stating the underlying cause last. _____</p> <p>(c) _____</p> <p>Coronary Occlusion</p> <p>Coronary Sclerosis</p> <p>Approximate interval between onset and death Sudden</p>								
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p>4</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Benedict Skitarelic</i></p> <p>EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>22b. DATE SIGNED Dec. 3, 1968</p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND</p>								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6 DEC 68	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK		23d. LOCATION (City or Town) County RFD#2 CUMBERLAND ALLEGANY MD.	(State)		
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD.		ADDRESS		25a. REC'D. BY REGISTRAR DEC 9 1968	25b. REGISTRAR'S SIGNATURE <i>Otteman, Linda</i>			



FOR STATE
HEALTH DEPT.

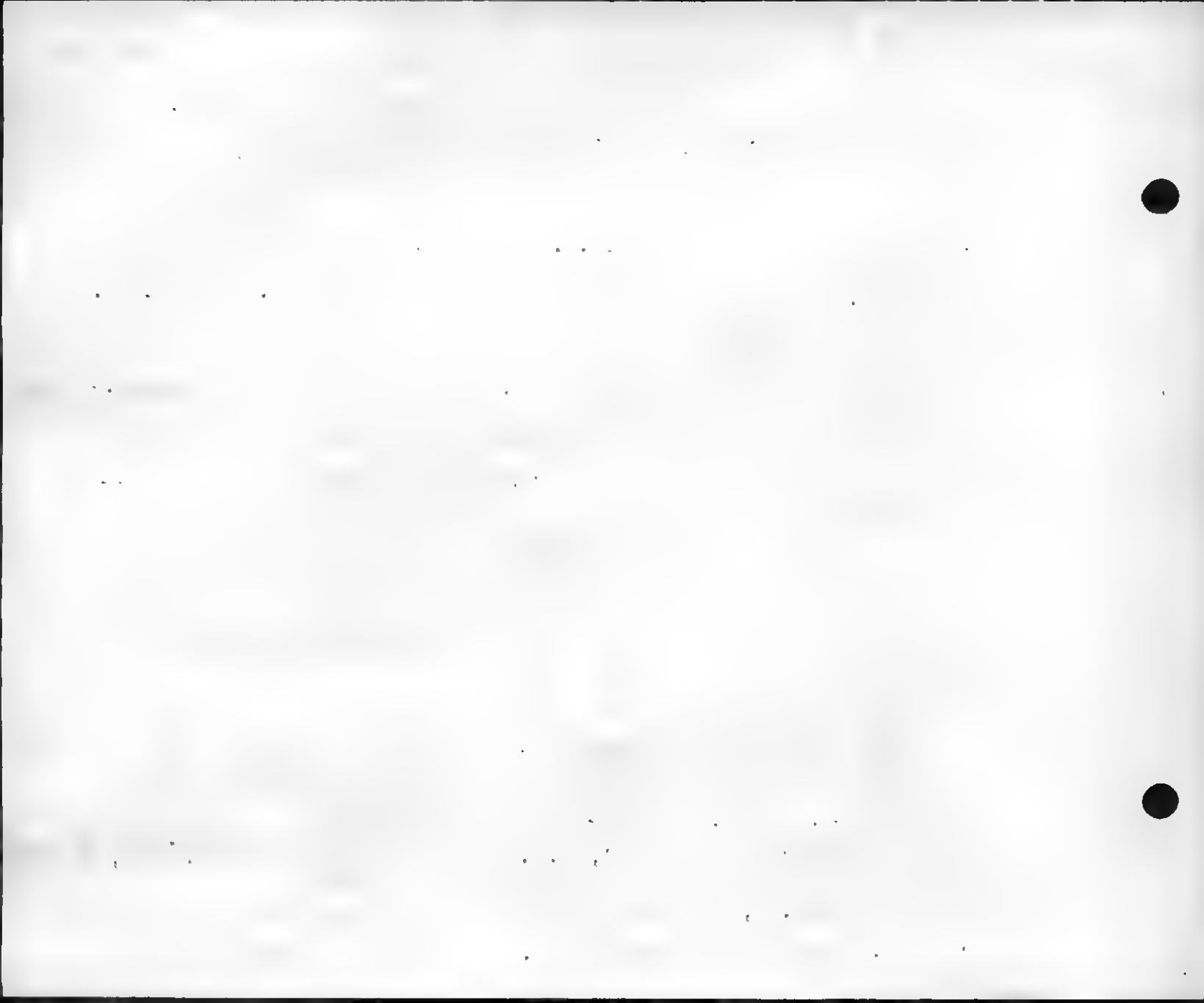
1
12528
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3 Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16739

1. DECEASED-NAME (Type or Print)		First Mary	Middle Catherine	Last Herboldsheimer	2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 28	Month Year 1968	Day 1a.m.	2b HOUR 120																								
3 SEX Female	4 RACE White	5 DATE OF BIRTH July 21, 1904	6 AGE (In years Mothers Day) 64 yrs	7 IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	8 IF UNDER 24 HRS DAYS <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Allegany	2c DATE PRONOUNCED DEAD Month Dec. 28	2d HOUR A Year 1968 1:20 M																								
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial H.			12a JSJA OCCUPATION (Kind of work done during most of working life, even if retired) Retired Tire Builder-Tire			12b KIND OF BUSINESS OR INDUSTRY Md.																								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 135 N. Mechanic St.																											
14 FATHER'S NAME John Earsom		15. MOTHER'S MAIDEN NAME Minnie Dowden																														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16b SOCIAL SECURITY NO. (If yes give name or dates of service)	17 INFORMANT Mrs. Leslie Brinkman, Cumberland, Md.-Sister			ADDRESS																										
<table border="1"> <tr> <td colspan="2">18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b)</td> <td colspan="3">CORONARY OCCLUSION</td> <td colspan="3">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN</td> </tr> <tr> <td colspan="2"></td> <td colspan="3">DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS</td> <td colspan="3">---</td> </tr> <tr> <td colspan="2"></td> <td colspan="3">DUE TO, OR AS A CONSEQUENCE OF (c)</td> <td colspan="3"></td> </tr> </table>									18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b)		CORONARY OCCLUSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS			---					DUE TO, OR AS A CONSEQUENCE OF (c)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b)		CORONARY OCCLUSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN																											
		DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS			---																											
		DUE TO, OR AS A CONSEQUENCE OF (c)																														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. PM	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 19																													
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No City or Town County State																													
<p>22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED Dec. 28, 1968 ADDRESS (Street, city, town, or county) Cumberland, Maryland</p>																																
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 31, 1968	23c NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d LOCATION (City or Town) Cumberland, Allegany, Md.	(County)	(State)																								
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS			25a REC'D BY REGISTRAR DATE JAN 3 1969	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>																										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16740

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

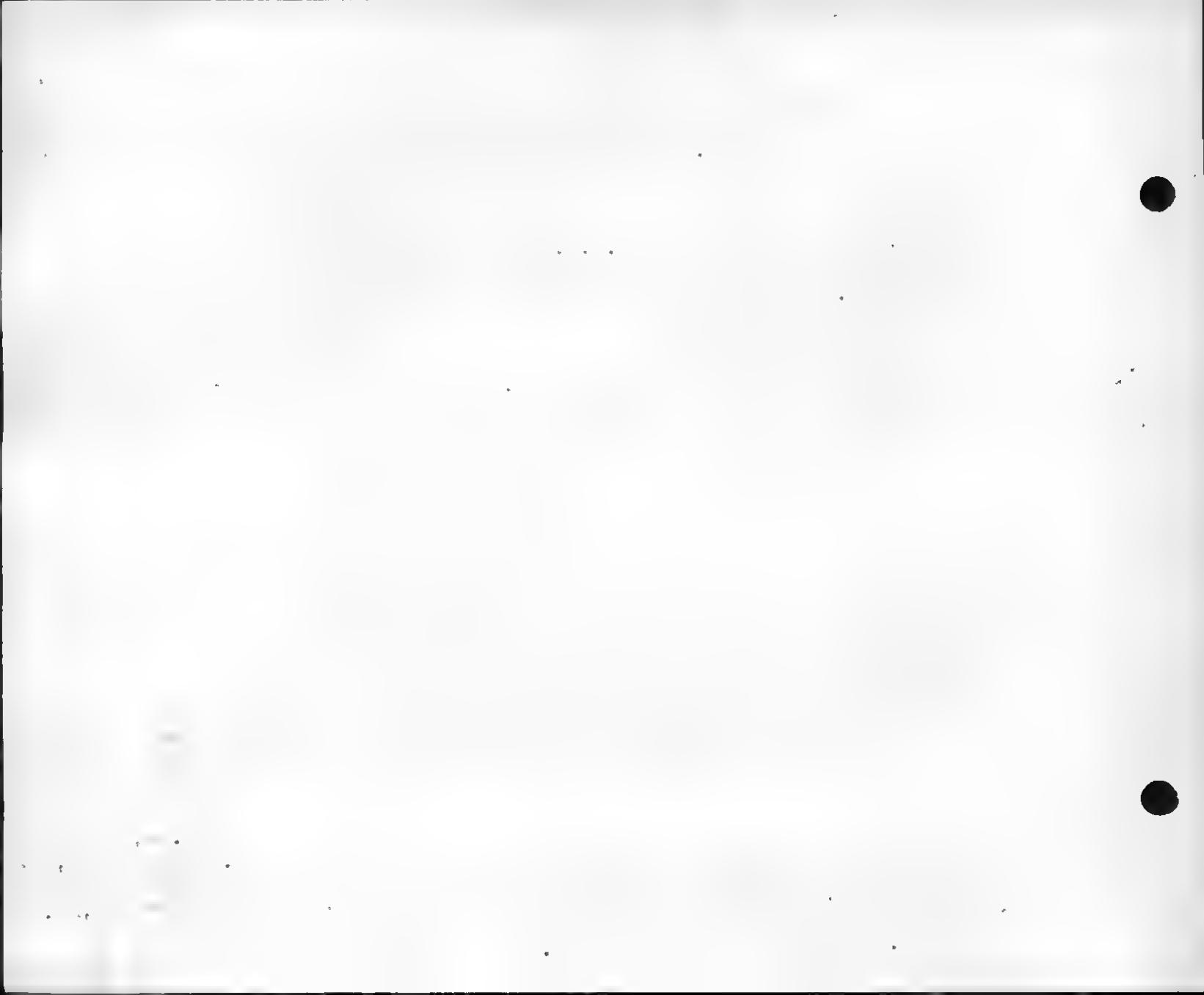
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR P 3:26M
JOHN H. JEFFRIES					12 23	68
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 4/8/17			6 AGE (in years last birthday) 51	F UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital above street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during last month or year if retired) ADMINISTRATIVE		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN MIDLAND	13d INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
14 FATHER'S NAME JOHN	Middle JEFFRIES	Last	15. MOTHER'S MAIDEN NAME First ANNE STEVENS	Middle JEFFRIES	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> (Type) YES	16b. SOCIAL SECURITY NO. 213 01 6083	17 INFORMANT SACRED HEART HOSPITAL	Address 900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Messic Subarachnoid Hemorrhage 1 day</i> 45-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3302						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.						
22b. SIGNATURE <i>Weisman</i>		DEGREE ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED <i>12/24/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		59 GREENE ST - CUMBERLAND, MD.		
DR. S. G. WEISMAN						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/26/1968	23c. NAME OF CEMETERY OR CREMATORIAL Memorial Park		23d. LOCATION (City or Town) Frostburg, Md.		
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME - LONACONING, MD.		ADDRESS		25a. RECEIVED BY REGISTRAR DEC 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE		

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												16741
1. DECEASED NAME (Type or Print)		First Sophia	Middle A.	Last Jolley	2a. DATE KNOWN OF EST. DEATH MATED		Month 12-10	Day 1968	Year 11:30	2b. AMOUR		
3 SEX Female	4 RACE White	5 DATE OF BIRTH July 2, 1899	6 AGE (In years last birthday) 69 YRS	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 12		Doy 10	Year 1968	11:30		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
10 CITY OR TOWN OF DEATH Cumberland			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			13a. STREET AND NUMBER Mexico Farms			
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Mexico Farms				
14. FATHER'S NAME First Frederick Bierman			15. MOTHER'S MAIDEN NAME First Minnie Schultz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Mr. Harold Jolley, Mexico Farms-Son			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Coronary Occlusion						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
(b) DUE TO, OR AS A CONSEQUENCE OF			Coronary Sclerosis						--			
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1201												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED Dec. 10, 1968			
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-13-1968		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS			25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

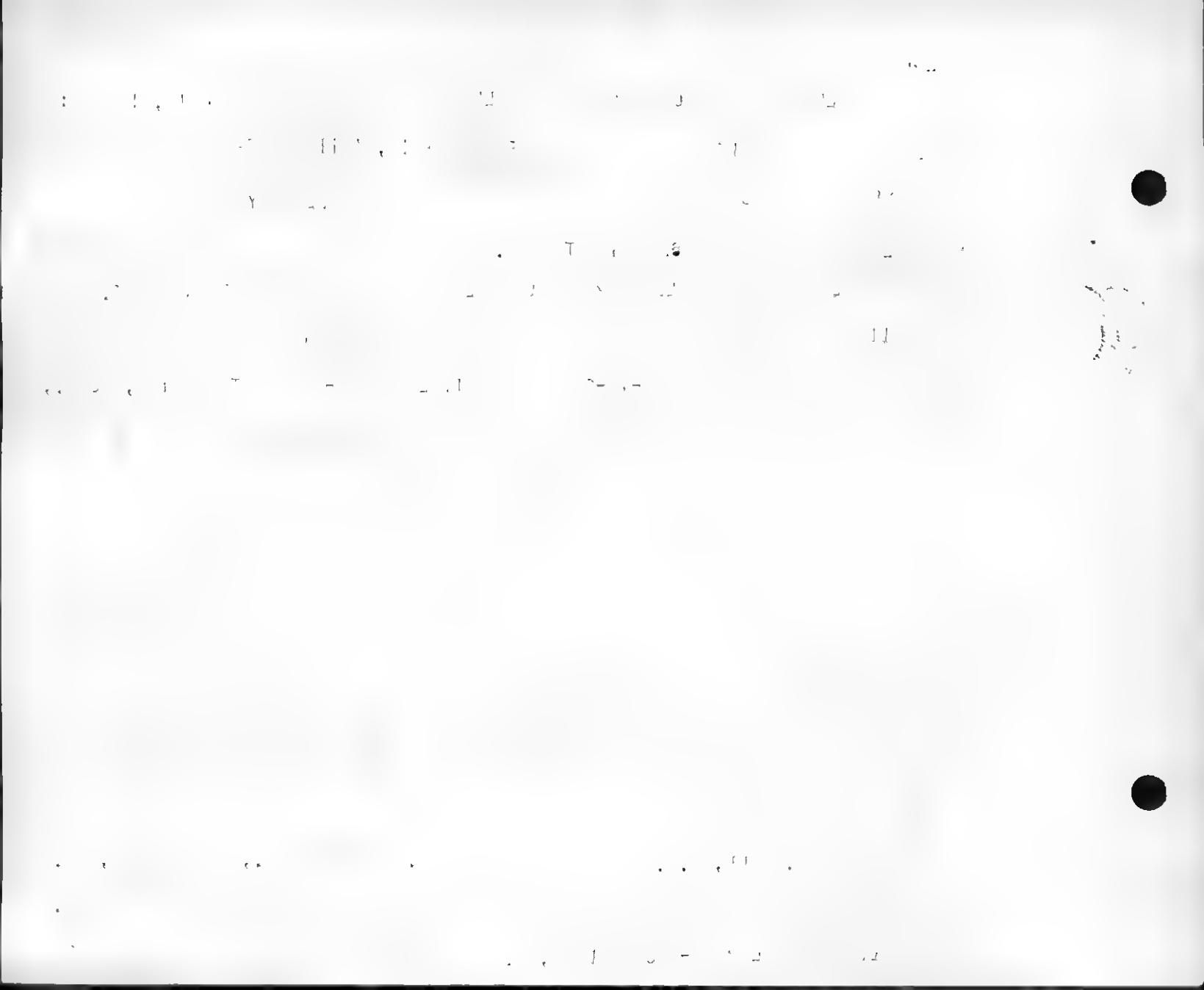
18729

16742

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ALFRED	Middle CONRAD	Lost KELLER	2a. DATE OF DEATH DECEMBER 14, 1968	2b. HOUR 4:25AM			
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH FEBRUARY 14, 1912	6. AGE (In years less than 100) 56-58 yrs.	F. UNCLER MONTHS 5	YEAR DAYS 0	IF UNCLER 24 MRS. HOURS 4	M.N. 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BODY & FENDER SHOP	12b. KIND OF BUSINESS OR INDUSTRY BODY & FENDER SHOP					
13a. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER MC GEES TRAILOR CT. CREEK R.				
14. FATHER'S NAME First WILLIAM	Middle C.	Lost KELLER	15. MOTHER'S MAIDEN NAME First MARGARET	Middle DORSEY	Lost 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 220-10-2623	17. INFORMANT HOSPITAL RECORD - 900 SETON DRIVE, CUMB., MD	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Danemysm	Rupture of Terminal aortic					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours		
19a. DATE OF OPERATION 451X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 			
22a. I certify that 0 (this hospital) attended the deceased from 12-13-1968 to 12-19-1968 , that 0 (we) last saw the deceased alive on 12-13-1968 , and that in 0 (our) opinion death occurred on the date and hour and from the causes stated above, 0 (we) (did) (did not) view the body after death.						22c. DATE SIGNED		
22b. SIGNATURE Earl R. Paul	DEGREE 	ATTENDING PHYS. X	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) EARL R. PAUL, M.D.	22e. ADDRESS 414 N. MECHANIC ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	23b. DATE Dec. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County) 	(State) 			
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME - CUMBERLAND, MD.	ADDRESS 	25a. REC'D BY REGISTRAR DA	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16730

CERTIFICATE OF DEATH

16743

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **M** and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First John	Middle Edward	Last Kroll	2a. DATE OF DEATH Month 12	Day 20	Year 1968	2b. HOUR M					
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7/7/1897			6. AGE (In years last birthday) 71	YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0		
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany			Md					
10 CITY OR TOWN OF DEATH Frostburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miders Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Baker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Midland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER								
14. FATHER'S NAME First John	Middle Kroll	Last	15. MOTHER'S MAIDEN NAME First Constance	Middle	Last Retallick	Address						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-01-6082A	17. INFORMANT John E. Kroll, Midland, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial ischemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause #109 Chronic coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Approximate Interval Between Onset and Death 1 year years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) Chronic Gastritis + enteritis												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or RFD No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from Mar. 1968 , to Dec. 1968 , that (I) (we) last saw the deceased alive on Dec. 1968 and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death												
22b. SIGNATURE Spangler, MD	22c. DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-21-68							
22d. PHYSICIAN'S NAME (Type) H.R. Miles, Jr. M.D.	22e. ADDRESS Lonaconing, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Memorial Park	23d. LOCATION (City or Town) Frostburg	(County) A.	(State) Md.							
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. RECD BY REGISTRAR DATE DEC 24 1968			25b. REC STRARS SIGNATURE Charles Judge							

4 - 5 - 2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16744

16731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First ANNIE	Middle	Last LEITH	20. DATE OF DEATH 12 11 68	2d. HOUR 9:15 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 9-6-16			6. AGE (In years last birthday) 32	IF UNDER 1 YEAR MONTHS YRS.	F. UNDER 24 HRS. HOURS MIN. 00 00 00
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Ins. Co.	
13a. USA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 207 GRAND AVENUE			
14. FATHER'S NAME First JAMES	Middle STEVENSON	Last	15. MOTHER'S MAIDEN NAME First MARY	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, No	16b. SOCIAL SECURITY NO 220-10-0609	17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concurrent lesions - 2° Carb. breast</i> BETWEEN ONSET AND DEATH <i>4 years,</i>							
due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause +X							
(b)							
due to, or as a consequence of last (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION 1964		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Car. Breast -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (1) (this hospital) attended the deceased from 10-22 , 19 68 , to 11-1-68 , 19 68 , that (1) (we) last saw the deceased alive on 10-22-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. F. Miltenberger</i>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER		22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/14/68	23c. NAME OF CEMETERY OR CREMATORIALy Zion Memorial Burial Park	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County)	(State)		
24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DEC 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16745

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First JOHN	Middle W.	Last LEWIS	2a. DATE OF DEATH Month Day Year DECEMBER 22 1968	2b. HOUR 3:30 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10/2/1898		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN ECKHART	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER -----		
14. FATHER'S NAME ABRAHAM	First MIDDLE LEWIS	15. MOTHER'S MAIDEN NAME MARtha		MIDDLE WILLISON	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO N.A.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Meteorite (Asteroid Perseid Meteorite)</i>						
DUE TO, OR AS A CONSEQUENCE OF conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause lost. (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Intense heat (Solar Flare) caused intense heat stroke</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 20, 1968</i> , to <i>Dec 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 22, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>DR. H. H. Himmelwright</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>12/21/68</i>	
22d. PHYSICIAN'S NAME (Type) DR. H. H. Himmelwright	22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/24/68	23c. NAME OF CEMETERY OR CREMATORIAL ECKHART CEMETERY	23d. LOCATION (City or Town) ECKHART, ALLEGANY, MD.	(County)	(State)	
24. FUNERAL DIRECTOR WALTER M. BOILERS, HAFFER-SOILERS FUNERAL HOME, 60 W. MAIN, FREDERICKSBURG	25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

VRAS 4,
30 JUN 1968



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 1(a), Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First MARY	Middle	Last LINDSAY	2a DATE KNOWN OF DEATH ESTI- MATED	Month Day Year	2b HOUR Dec. 8, 1968 11:30p
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH JUNE 22, 1899	6 AGE (In years or months) 69 yrs	IF UNDER 1 YEAR MONTHS GAYS	IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY U.S.A.		8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	2c DATE PRONOUNCED DEAD Month Day Year December 8, 1968 11:30p M	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WORK		12b KIND OF BUSINESS OR INDUSTRY OWN HOME
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN FROSTBURG	13d INS DE CITY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER ROUTE 1	
14 FATHER'S NAME First JOHN		Middle LINDSAY	Last	15. MOTHER'S MAIDEN NAME First SARAH	Middle	Last WILLIAMS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give name or dates of service) NONE		17. INFORMANT JOHN A. LINDSAY. RT. 1, BOX 59, FROSTBURG, MD		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 85/X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
Fracture of Right Femur 4 Days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a. Diabetes, Chronic Glomerulonephritis, ASCV Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 5:00 - Dec. 4 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell at home			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No Rt. # 1, Frostburg, Allegany, Maryland		City or Town County State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE DEC. 11, 1968		23c NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK		23d LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24 FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.		ADDRESS 21532		25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

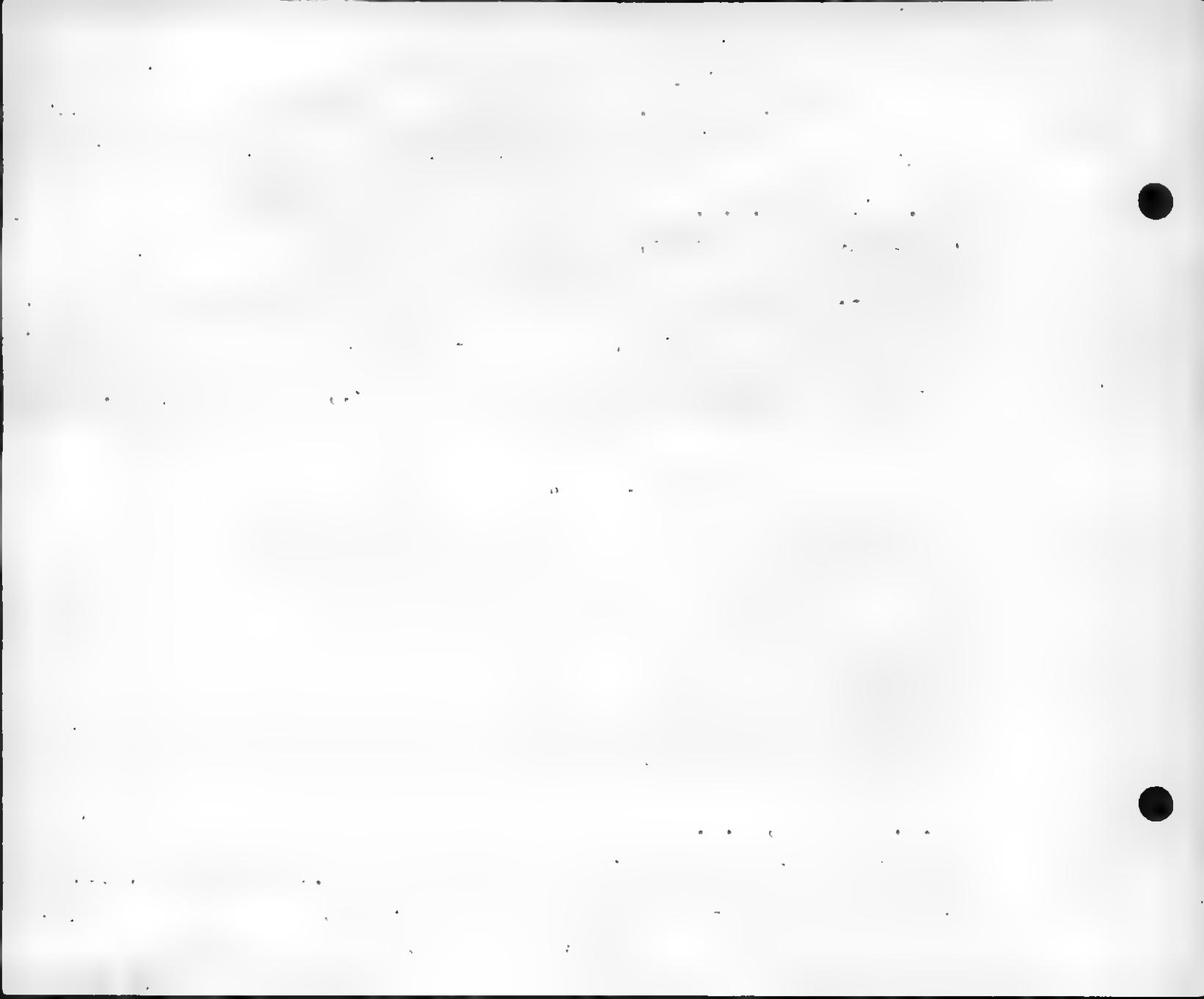
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16747

1. DECEASED NAME (Type or print)	First HOWARD	Middle W.	Last MALCOLM	2d. DATE OF DEATH DECEMBER	2b. HOUR 684:00 M
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 10-13-99	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	F. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) R.F.D. 1, Paw Paw, W. Va.			12b. KIND OF BUSINESS OR INDUSTRY BREWERY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) W.VA. MD. Md. Allegany, Morean	13c. CITY OR TOWN Paw Paw	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER R.F.D. 1, Paw Paw, W. Va.		
14. FATHER'S NAME First JACOB	Middle MALCOLM	15. MOTHER'S MAIDEN NAME First ELIZABETH	Middle COX		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 212 18 1636	17. INFORMANT MEMORIAL HOSP., CUMBERLAND, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193X			Bronchopneumonia + Leat failure 2 d		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 194X			Carcinomatosis to lungs, cervical nodes 2 months		
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Thyroid			2 months?		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic heart disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	11/10/1968 to 12/11/1968				
22b. SIGNATURE S.G. WEISMAN, M.D.	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12/11/1968
22d. PHYSICIAN'S NAME (Type) Weisman	22e. ADDRESS 59 GREEN ST. CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/13/1968	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Church	23d. LOCATION (City or Town) Levels, (Hampshire) W. Va.	(County) W. Va.	(State)
24. FUNERAL DIRECTOR Johnson F. Homes.	ADDRESS Berkeley Springs, W.	25a. REC'D. BY REGISTRAR V.A. DA	25b. REGISTRAR'S SIGNATURE DEC 19 1968 Charles Judge		



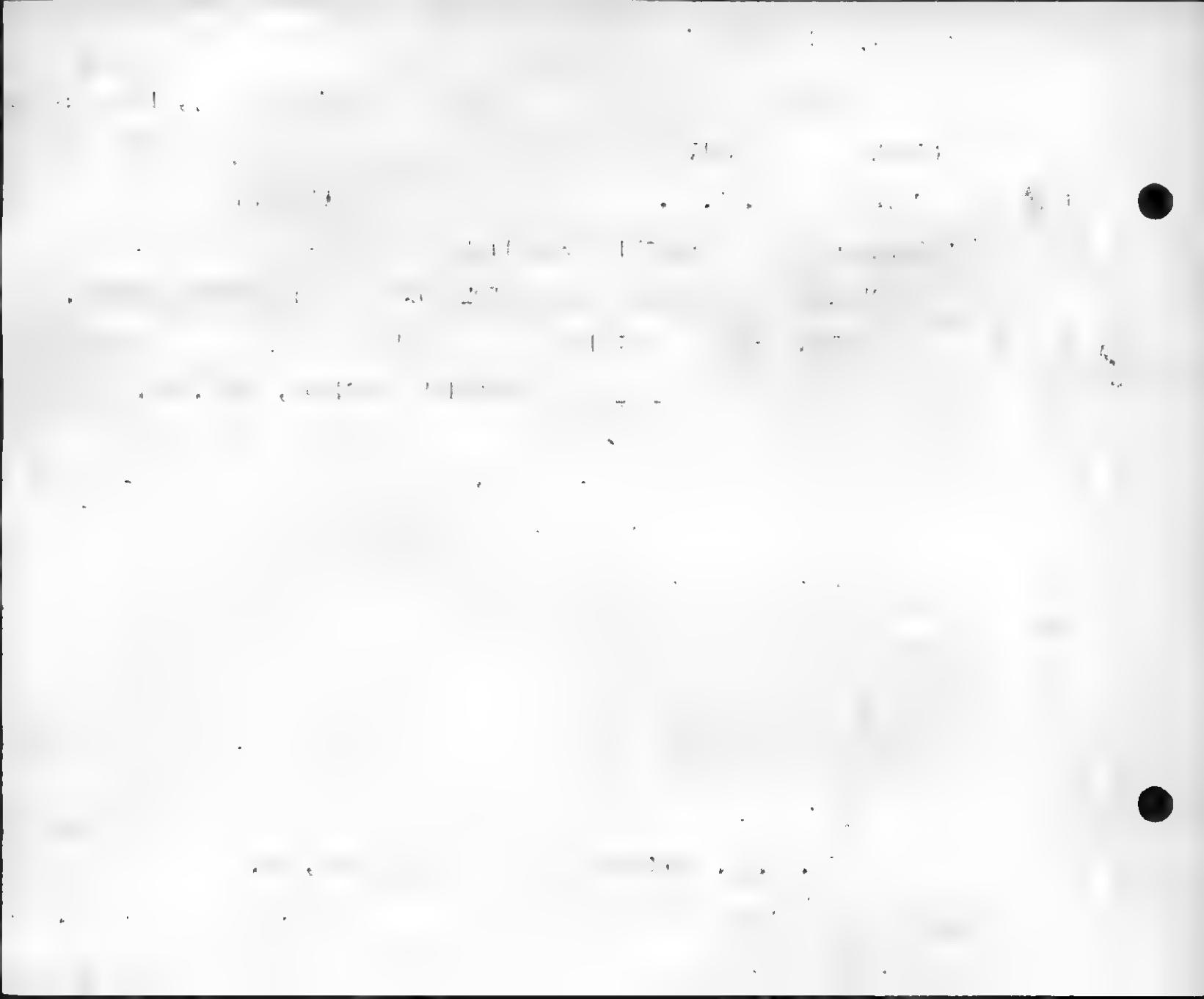
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First MARY	Middle A	Lost MALIN	2d. DATE OF DEATH DECEMBER 7, 1968	2b. HOUR 6:45 PM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH April 27, 1892		6. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) OHIO	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH * ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give state) MEMORIAL HOSPITAL		12a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	12c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	12b. STREET AND NUMBER 418 WASHINGTON ST.
14. FATHER'S NAME First REED	Middle BED	Lost SUTLIFF	15. MOTHER'S MAIDEN NAME First CLARA	Middle ESTHER	Last CARLTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 217-42-6591	17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 41C / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Myocardial Infarction, acute, antemortem						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) A.S. Cardiorvitic Disease						8 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic cholecystitis with Cholelithiasis						
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>W. A. Van Ormer, M.D.</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 7 Dec. 68		
22d. PHYSICIAN'S NAME (Type)	DR. W. A. VANORMER	22e. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/10/1968	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Near Cumberland Alleg. Md	(County)	(State)	
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>	ADDRESS John J. Hafer, Jr., 290 Balto Ave, Cumberland	25a. REC'D BY REGISTRAR DEC 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First MARY	Middle E.	Last MANLEY	2a. DATE OF DEATH Month 12 Day 19 Year 68	2b. HOUR 4:50 M	
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 01-07-95		6. AGE (in years lost birthday) 73 yrs.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY,		Md.	
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY TEACHER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY Allegany		13c. CITY OR TOWN MIDLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER O'MARASTREET, BOX 41	
14. FATHER'S NAME WILLIAM		First WILLIAM	Middle MANLEY	Last MANLEY	15. MOTHER'S MAIDEN NAME First (LANGAN) CATHERINE		Middle MANLEY	Last MANLEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 212-38-5601		17. INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.		Address MD. 21502		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MOS	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO-CARCINOMA, LEFT OVARY</p> <p>DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF lost. (c)</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from 5 - 6, 19 57 to 12 - 19, 19 68, that (I) (we) last saw the deceased alive on 12 - 18 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>Roger L. Ballin, M.D.</i>		22c. DEGREE DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.		22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/21/1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Michaels Cemetery		23d. LOCATION (City or Town) Frostburg, Md.		(County) (State)	
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME-8 E. MAIN ST., LONACONING MD		ADDRESS MD		25a. REGISTRATION DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE <i>Juaga</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages and director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

10737

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16750

Item 6 FilmG407 12/18/68 kk

1. DECEASED NAME (Type or print)	First ELIZABETH	Middle W.	Lost MARTIN	2a. DATE OF DEATH DEC. Month 7 Day 1968 or	2b. HOUR 6:00 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH DEC. 17, 1882	6. AGE (In years lost birthday) 85 86 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) ENGLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL	12a. USWAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN MT. SAVAGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First RICHARD	Middle WATKINS	15. MOTHER'S MAIDEN NAME First EDITH	Middle JENKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/>	16b. SOCIAL SECURITY NO.	17. INFORMANT MRS. ELSIE BARB, MT. SAVAGE, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1550			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Carcinomatosis					
(b) Carcinoma of upper G.I. Tract					
DUE TO, OR AS A CONSEQUENCE OF last (c) origin probably in hilus of liver. 6 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1550 Generalized atherosclerosis, moderate.					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritoneal effusion.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to Dec 8, 1968, that (I) () last saw the deceased alive on Dec 8, 1968, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () () did not view the body after death.					
22b. SIGNATURE <i>Alvin J. Walters M.P.</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/9/68.			
22d. PHYSICIAN'S NAME (Type) DR. ALVIN J. WALTERS	22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIUM METHODIST CEMETERY	23d. LOCATION (City or Town) MT. SAVAGE, MD.	(County)	(State)
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 13 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16751

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in my funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~grave paper~~ ^{grave papers} and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours.

1. DECEASED NAME (Type or print)		First LOUISE	Middle B.	Last MARTIN	2a. DATE OF DEATH Month Dec.	Day 20	Year 1968	2b. HOUR 1:55PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 4, 1894	6. AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last 6 months of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER C STREET, POTOMAC PARK				
14. FATHER'S NAME First AJOHN		Middle BRINKER	Last 	15. MOTHER'S MAIDEN NAME First (POWERS)	Middle ANNIE	Last BRINKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT HOSPITAL RECORD, CUMBERLAND, MD. 21502		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 203X		DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Malignant Tumors								
DUE TO, OR AS A CONSEQUENCE OF (c) 203X										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chloroethane										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (i) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Clarence Vincent, M.D.</i>		DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Dec. 22, 1968				
22d. PHYSICIAN'S NAME (Type) CLARENCE VINCENT, M.D.		22e. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, RE-BURIAL (specify) Burial		23b. DATE Dec. 23, 1968		23c. NAME OF CEMETERY OR CREMATORIUM SS. Peter Paul Cemetery		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS 		25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 26 1968		
VR A15 30M REV. 1/66										

W E T

Y = {

T U G G I

E T T

()

R E

J Y D

J

J V

T U G G I

S

S

J

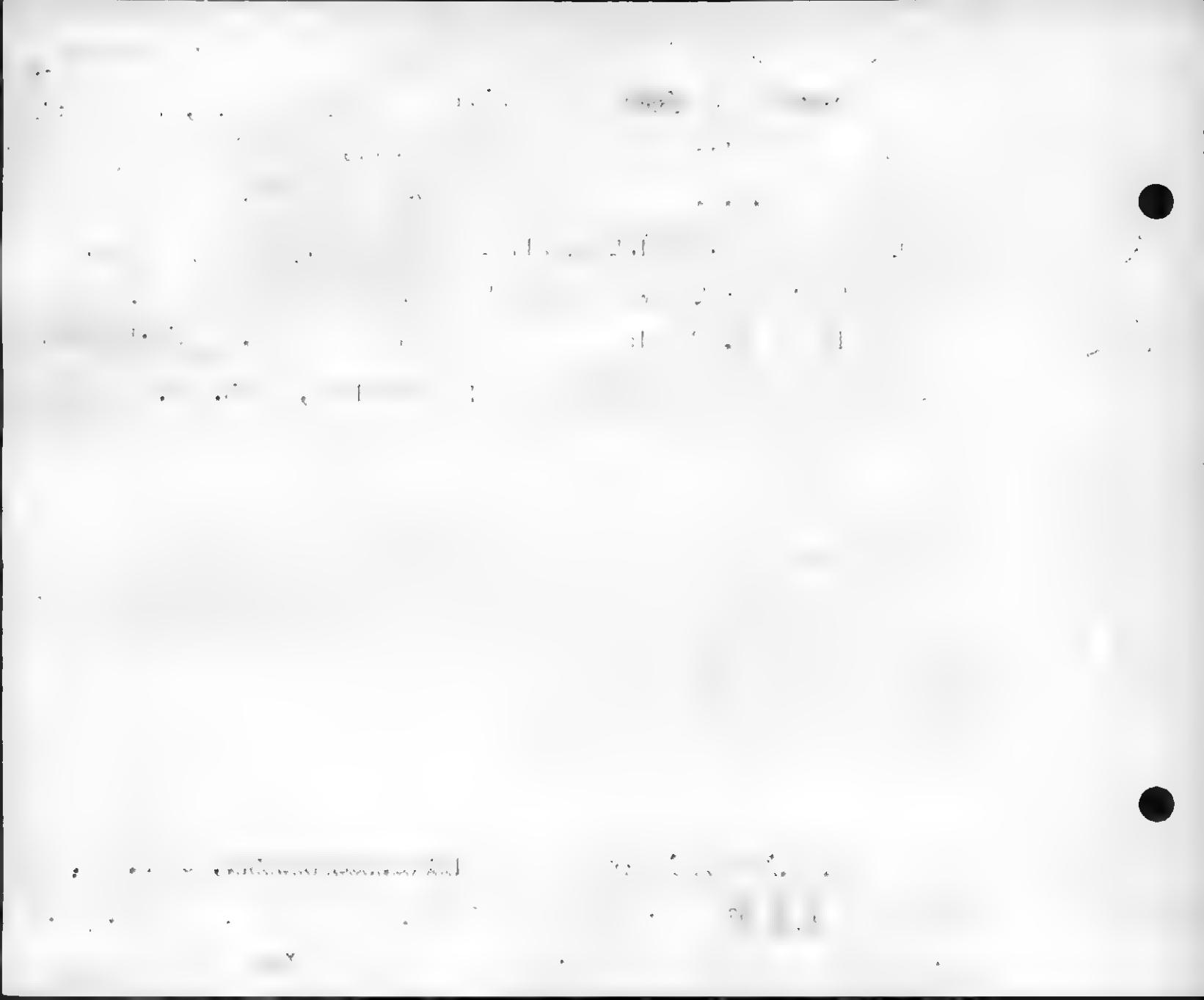
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First David	Middle Scott	Last MARVIN	2a. DATE OF DEATH Month DECEMBER	Day 28, 1968	Year 6:35 M	2b. HOUR 6:35 M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH DECEMBER 27, 1968			6. AGE (In years at birthday) 1 YRS.		IF UNDER 1 YEAR MONTHS 0	F. UNDER 24 HRS HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, residence before admission) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 109 Frederick St.			
14. FATHER'S NAME First DAVID		Middle S.	Last MARVIN	15. MOTHER'S MAIDEN NAME First MARY		Middle L.	Last Brittenham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No,		16b. SOCIAL SECURITY NO. (If yes give name or dates of service) None		17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <i>Prematurity</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7715									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert D. Brodell</i>		22c. DATE SIGNED 12/29/68							
22d. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL		22e. ADDRESS XXXXXXXXXXXXXX CUMB. MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/69	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park,			23d. LOCATION (City or Town) (County) Cumberland, Allegany Md.	(State)		
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland			25a. REC'D BY REGISTRAR JAN 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16753

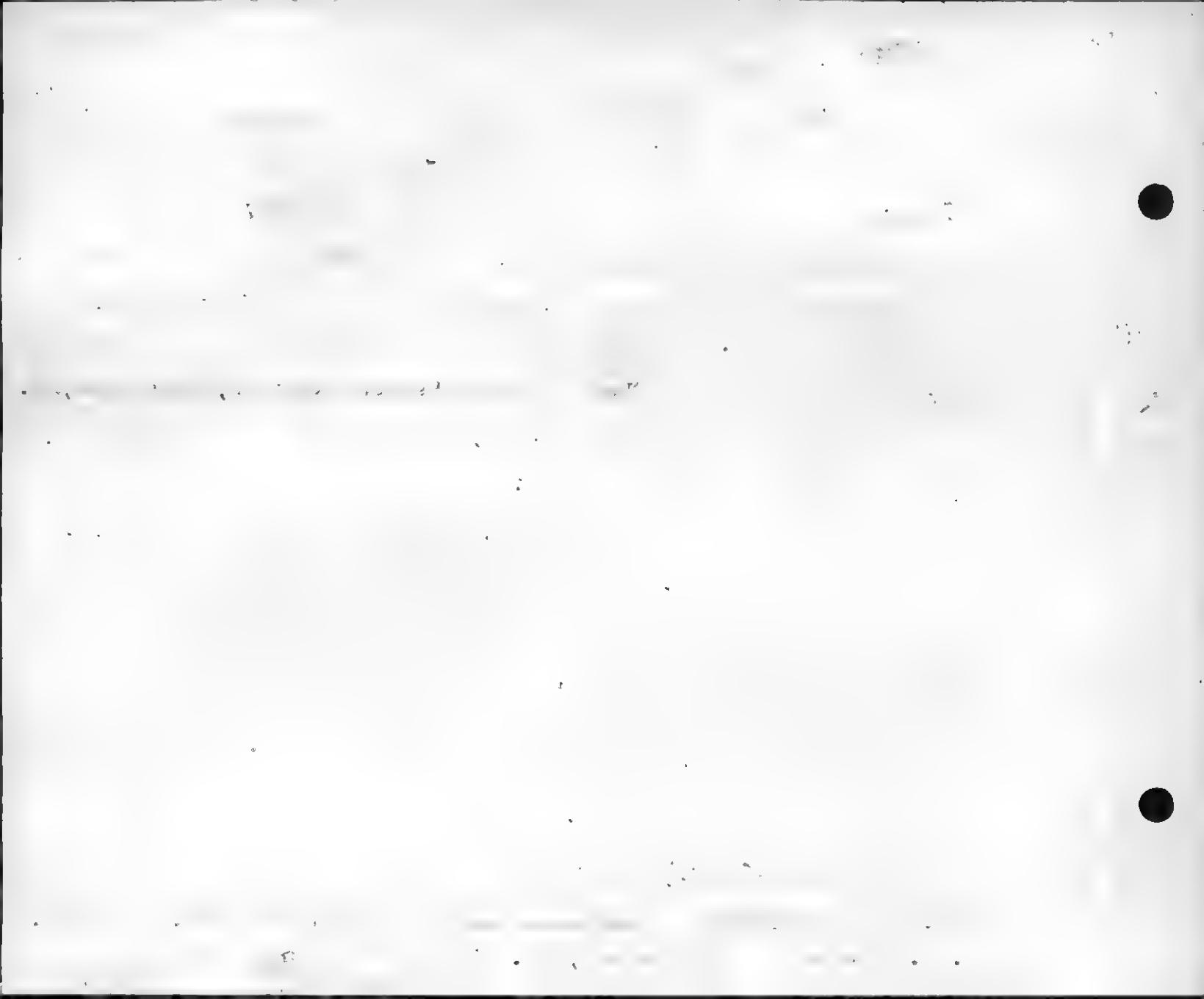
CERTIFICATE OF DEATH

16740

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or print)		First John	Middle William	Last McCorkle	2a DATE OF DEATH Month December	Day 25	Year 1968	2b HOUR 4:15 A.M.
3 SEX Male	4 RACE White	5. DATE OF BIRTH May 8, 1882		6. AGE (In years lost birthday) 86	IF UNDER 1 YEAR MONTHS YRS.	F UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Penna	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 952 Glenwood Street			
14 FATHER'S NAME First Peter		Middle H.	Last McCorkle	15. MOTHER'S MAIDEN NAME First Margaret	Middle	Last Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service) None		17 INFORMANT Sylvan Retreat Records, Cumberland, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Inflammatus 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Ch. A. S.H.A.T. DUE TO, OR AS A CONSEQUENCE OF (c) Arterio Sclerosis Barkineus Glauco APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx 3 yrs. many years many years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Paroxysmal Disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Apr. 15, 1967 , to Dec. 25, 1968 , that (I) (we) last saw the deceased alive on Dec. 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John L. Jeffer</i>		22c. DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED 12-30-68				
22d. PHYSICIAN'S NAME (Type) <i>John L. Jeffer, MD</i>		22e. ADDRESS						
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE 12/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Henderson Cemetery	23d. LOCATION (City or Town) Harmer Twnshp.	(County) Penna.	(State)		
24. FUNERAL DIRECTOR A. M. Clowes		ADDRESS Springdale, Pa. 15144	25a. REC'D. BY REGISTRAR DATE JAN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

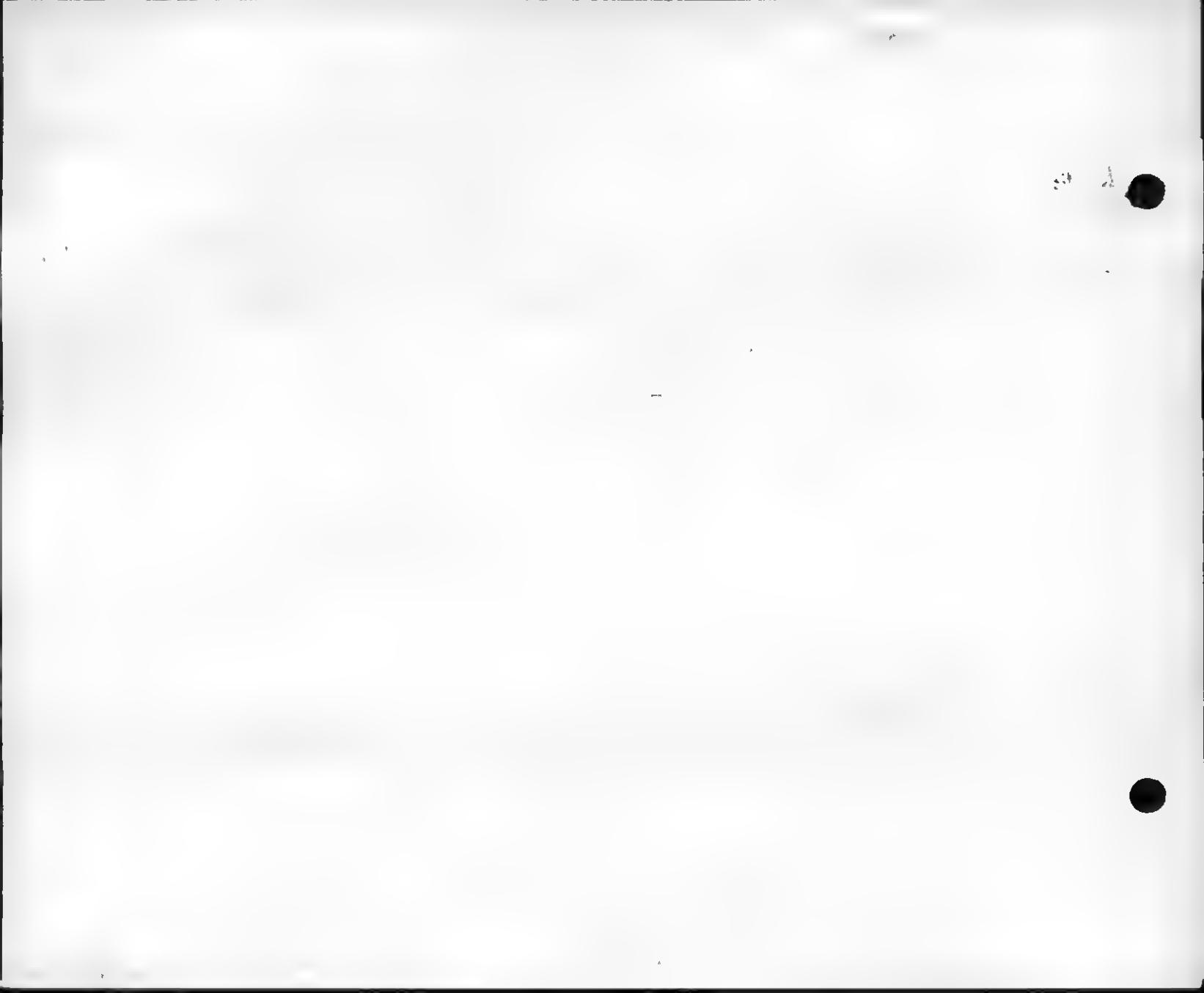
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16754

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JOHN	Middle W.	Last MC CULLOUGH	2d. DATE OF DEATH Month DEC. Day 22 Year 1968	2b. HOUR M
3. SEX MALE	4 RACE WHITE	S. DATE OF BIRTH JULY 25, 1886	6. AGE (In years last birthday) 82	F. UNDER 1 YEAR MONTHS 0	If UNDER 24 MONTHS HOURS 0
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED MAIL CARRIER	12b. KIND OF BUSINESS OR INDUSTRY GOV'T.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 179 E. MAIN STREET	
14. FATHER'S NAME First WILLIAM	Middle W. McCULLOUGH	15. MOTHER'S MAIDEN NAME First ESTELLE	Middle HORNE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 266-76-9394	17. INFORMANT MM. M. McCULLOUGH, FROSTBURG, MD. 21532	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 48 hours</p> <p>431.9 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>351X</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i> years</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <p><i>Carcinoma of Prostate Chronic Pul. Fibrosis</i></p>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 21, 1968</u>, to <u>Dec 22, 1968</u>, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Dec 22, 1968</u>, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Leslie Miles</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 12.23.68		
22d. PHYSICIAN'S NAME (Type) DR. LESLIE MILES		22e. ADDRESS LONACONING, MD.			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE DEC. 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL MERCER CITIZENS CEMETERY	23d. LOCATION (City or Town) MERCER, PA.	(County)	(State)
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. 21532	ADDRESS	25a. REC'D BY REGISTRAR DEC 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16755

1 DECEASED NAME (Type or Print)		First PATRICK	Middle RAYMOND	Last McGEADY	2a DATE KNOWN OF ESTI- DEATH MATED	Month <input checked="" type="checkbox"/> DECEMBER	Day 2	Year 1968	2b HOUR 830P
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MAY 8, 1898	6 AGE (in years since birthday) 70 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2c DATE PRONONCED DEAD DECEMBER Day 2 Year 1968	2d HOUR 830P
7a BIRTHPLACE (State or foreign country) OCEAN, MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH ALLEGANY			
8b WIDOWED <input type="checkbox"/>		8c DIVORCED <input type="checkbox"/>							
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital 911-111-1111-1111) MEMORIAL HOSPITAL-DOA			12a USUAL OCCUPATION (Kind of work done during day) RETIRED PAINTING CONTRACTOR			12b KIND OF BUSINESS OR TRADE (If not in hospital) RETIRED PAINTING CONTRACTOR	
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 303 DECATUR STREET			
14 FATHER'S NAME First JOHN		Middle J.	Last McGEADY	15. MOTHER'S MAIDEN NAME First JULIA		Middle GAVANAUGH	Last GAVANAUGH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b SOCIAL SECURITY NO. (If yes give war or dates of service) 218-10-9929A		17. INFORMANT MRS SARAH McGEADY		ADDRESS 303 DECATUR ST CUMBERLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)</p>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4109									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a MEDICAL CERTIFICATE ON EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State	
<p>22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Benedict Skitarlic</i></p> <p>EXAMINER'S NAME (Type) BENEDICT SKITARLIC, M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cumberland, Md., U.S.A.</p> <p>22b DATE SIGNED DECEMBER 3, 1968</p>									
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE DEC 5, 1968		23c NAME OF CEMETERY OR CREMATORIUM ST. PETER & PAUL CATH. CEMT.		23d LOCATION (City or Town) CUMBERLAND ALLEGANY MD.		(County) (State)	
24 FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE		ADDRESS 404 DECATUR ST CUMBERLAND, MARYLAND		25a. REC'D BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Gage</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 2M3. Page 5 may be retained for your files.

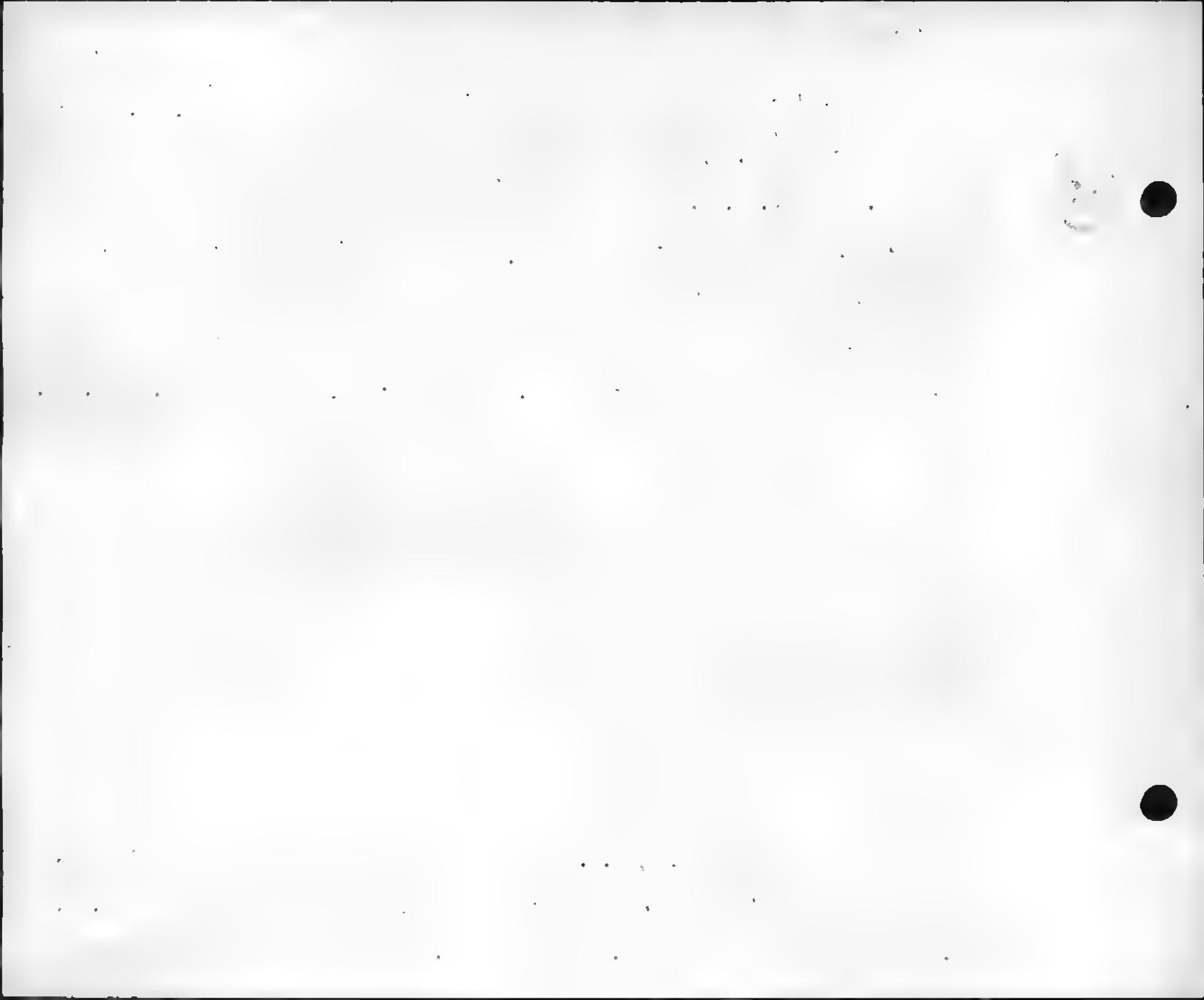
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
16743 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16756

1. DECEASED NAME (Type or Print)	First <i>Jean'ne</i>	Middle <i>Thelma</i>	Last <i>McKeivier</i>	20 DATE KNOWN OF ESTI. DEATH MATED Month Day Year	2b HOUR <i>Dec. 21, 1968 2:40 am</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Aug. 1, 1939</i>	6 AGE (in years at birthday) <i>29 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Penna.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Allegany</i>	2c DATE PRONONC'D DEAD Month Day Year <i>December 21, 1968 2:40 a.m.</i>	2d HOUR <i>2:40 am</i>
10. CITY OR TOWN OF DEATH <i>Cumberland,</i>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>SACRED HEART HOSP. DOA</i>			12a USUAL OCCUPATION (Kind of work done but no most of working life even if retired.) <i>Housewife & Hostess</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Restaurant.</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Allegany</i>	13c. CITY OR TOWN <i>Cumberland,</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>205 Sunset Drive,</i>	
14. FATHER'S NAME First <i>James</i>	Middle <i>--</i>	Last <i>Rhinehart</i>	15. MOTHER'S MAIDEN NAME First <i>Freda</i>	Middle <i>--</i>	Last <i>Parks</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No,</i>	16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>272-36-3081</i>	17. INFORMANT <i>L. Karl McKeivier, 205 Sunset Dr. Cumb. Md.</i>	ADDRESS <i>21502</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 Minutes</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>9520</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Carbon monoxide poisoning</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) (AUTO EXHAUST--SUICIDE)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>1721</i>					
19a. DATE OF OPERATION <i>1721</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Car exhaust</i>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Carbon monoxide poisoning</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Car exhaust</i>	21f. LOCATION Street or R.F.D. No <i>1721</i>	City or Town <i>Cumberland</i>	County <i>Allegany</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					
23a. BURIAL CREMATION, CREMATORIUM <i>Cremation</i>	23b. DATE <i>12/23/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Crematory</i>	23d. LOCATION (City or Town) <i>Washington,</i>	(County) <i>D. C.</i>	(State)
24. FUNERAL DIRECTOR <i>H. Wayne George 202 Greene St. Cumberland, Md.</i>	ADDRESS	25. REGD BY REGISTRAR DATE <i>DEC 26 1968</i>	26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



16744

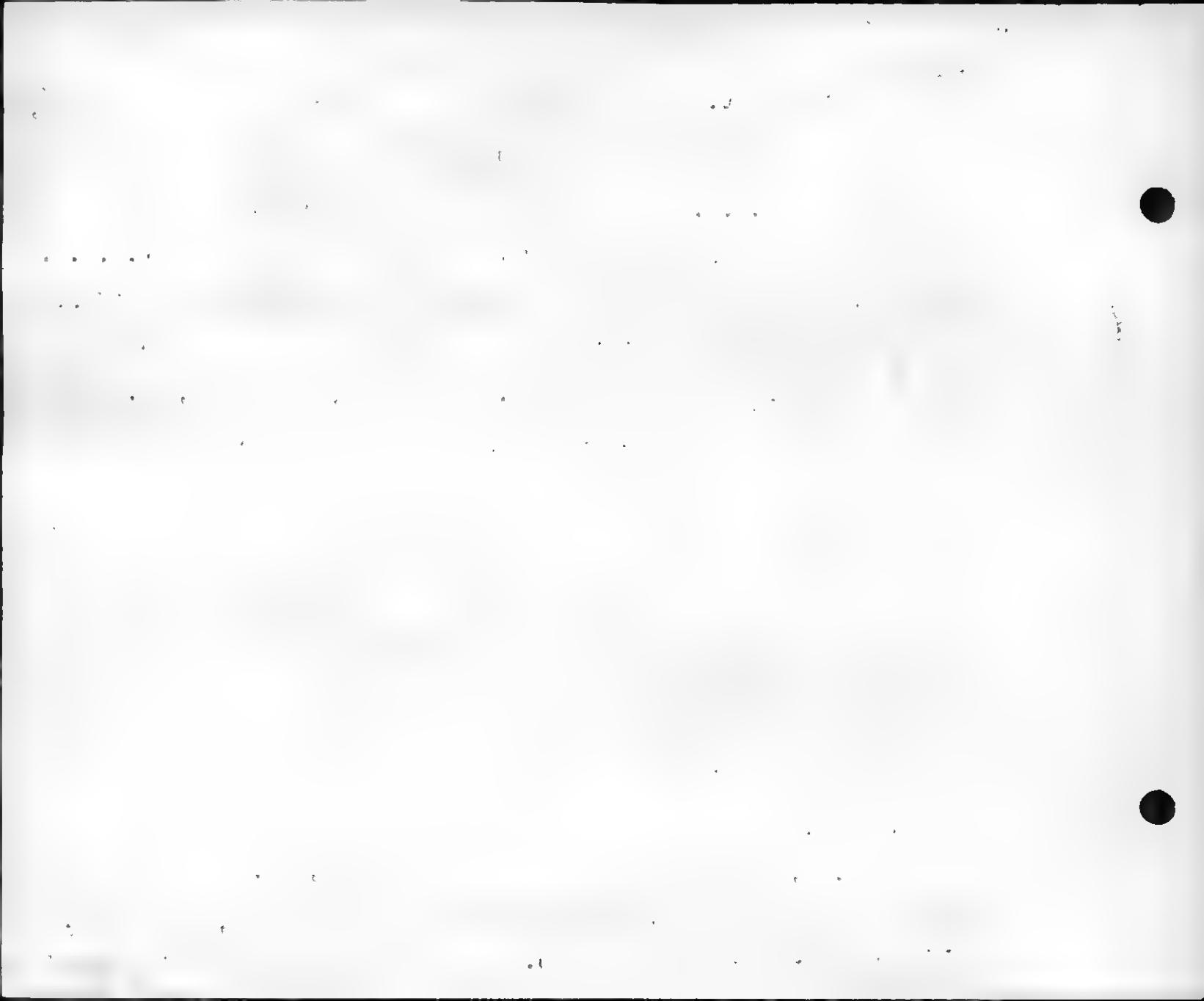
FD-291

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16757

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		IRVIN	Middle	Last	2a. DATE OF DEATH	12-8-1968	Day	Year	2b. HOUR 12A.M.	
3 SEX		4 RACE	5. DATE OF BIRTH			6 AGE (In years last birthday) 41		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE		WHITE	1-28-1927			YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
VIRGINIA		U.S.A.				ALLEGANY			Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (Type street address))			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL			CUMBERLAND			B.O.R.R.		
13a. USL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MARYLAND		ALLEGANY	CUMBERLAND	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		828 LAFAYETTE AVE.,				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			Middle	Last	
		JOHN		MERICA	ESSIE				BAKER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
Yes		War II		Mrs. June Merica, Cumberland, Md.-Wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancast (Superior Sulcus Tumor), Rt lung, Uncertain</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF last (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 20, 1968</u> , to <u>Dec. 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>DR. C.Y. BADIDIAN</u>		DEGREE		ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>12-9-68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			CUMBERLAND, MD.					
DR. C.Y. BADIDIAN										
23a. BURIAL, CREMATION, Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Specify		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION (City or Town)		(County)	(State)
Dec. 10, 1968		Mt. Herman Cemetery					Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.					DEC 13 1968		Charles Judge			



16745

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16758

Item 2b, Film G407 12/23/68 kk

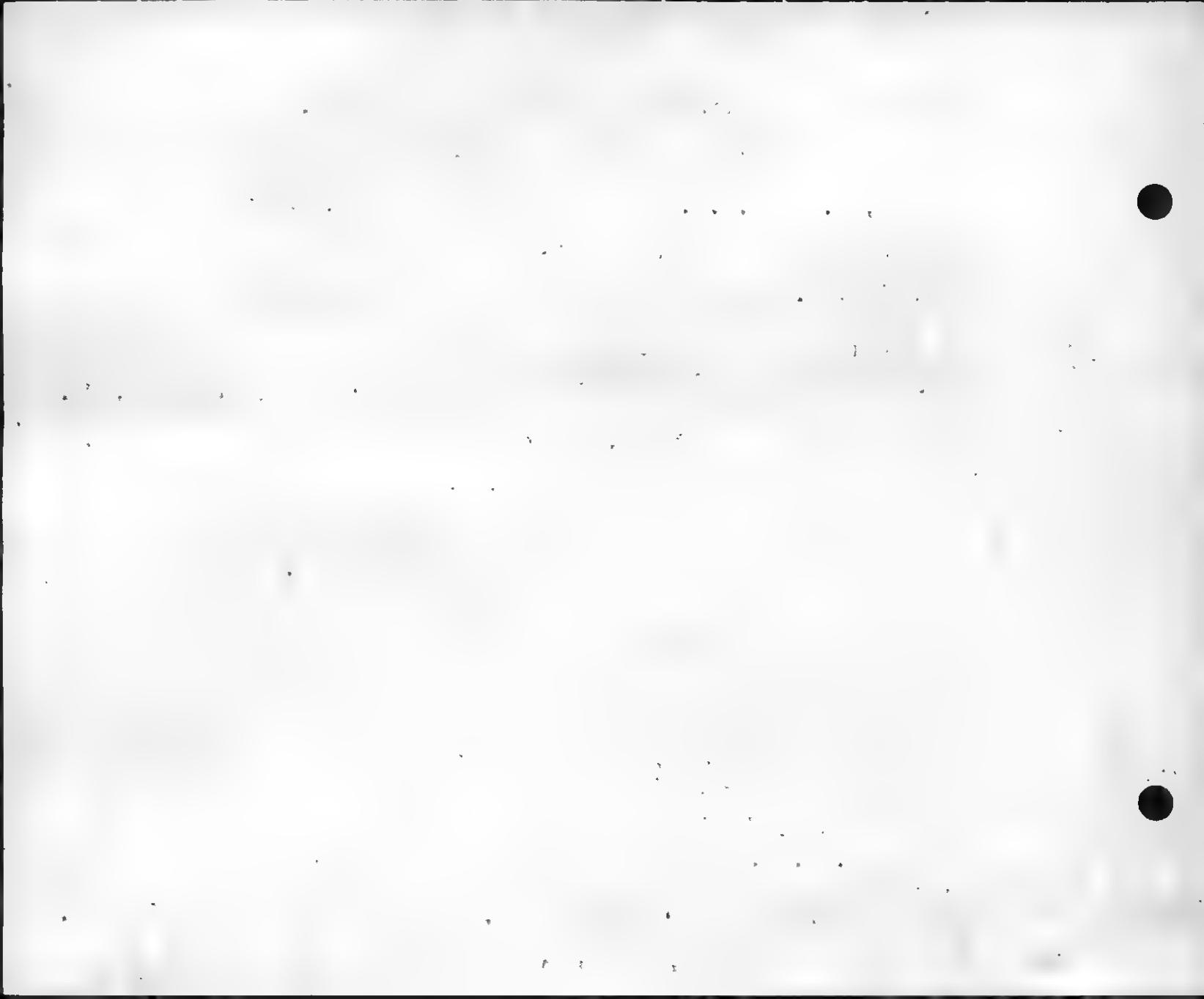
CERTIFICATE OF DEATH

26 HOURS
1:25

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial permit. This permit may be removed and filed with the State Dept. of Health prior to burial, cremation, or removal, and may be filed with the State Dept. of Health within 24 hours after death.

1. DECEASED NAME (Type/Thomas)	First ISAAC	Middle METZ	Last	2d. DATE OF DEATH DEC. Month 7 Day 1968	26 HOURS 1:25	
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 10-14-1894	6. AGE (In years last birthday) 74 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) BARTON, M.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13a. RESIDENCE (Where deceased lived, if institution Residence before admission) BARTON, MD.	13b. CITY OR TOWN ALLEGANY	13c. CITY OR TOWN BARTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER BOX 265		
14. FATHER'S NAME WILLIAM	First METZ	Middle ELLAN	Last POLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown	16b. SOCIAL SECURITY NO. 183 01 8332	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Staphylococcal Septicemia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks						
4 (1) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Vascular Erysina & Ulcer</i> 1 month						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Drabek</i> <i>Cysto-bladder & Disease</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>12/6/68</i> , that (I) (we) last saw the deceased alive on <i>12/3/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <i>Weissman</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/7/68	
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22e. ADDRESS CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cem.		23d. LOCATION (City or Town) Moscow Mills, Allegany Md.	(County) (State)
24. FUNERAL DIRECTOR Boal Funeral Home		Main St. ADDRESS Westernport, Md. 21562	25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16746

16759

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)				First FRANCIS	Middle J.	Last MICHAELS	2a. DATE OF DEATH Month 12 Day 18 Year 68	2b. HOURA 5:07M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 06-18-00		6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY,			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY CELANESE COR			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 531 DILLEY STREET	
14. FATHER'S NAME First JOSEPH		Middle 	Last MICHAELS	15. MOTHER'S MAIDEN NAME First (MARTIN) ANNIE		Middle 	Last MICHAELS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 214-07-3010		17. INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,		Address MD. 21502			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis.</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>Circumstances of the death.</i></p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec 11, 1968 , to Dec 18, 1968 , that (I) (<input type="checkbox"/>) last saw the deceased alive on Dec 18, 1968 , and that in (my) (<input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input type="checkbox"/>) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Clarence J. Vincent, M.D.</i>		22c. DEGREE M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.	DATE SIGNED 12/10/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Seton Drive							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/20/68		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Ph.		23d. LOCATION (City or Town) Cumberland		(County) Md.	(State)
24. FUNERAL DIRECTOR STEIN FUNERAL HOME, 117 FREDERICK ST., CUMB., MD.		ADDRESS		25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

$T_{\text{max}} = T_0 + \Delta T$

卷之三

• 14

— 1 —

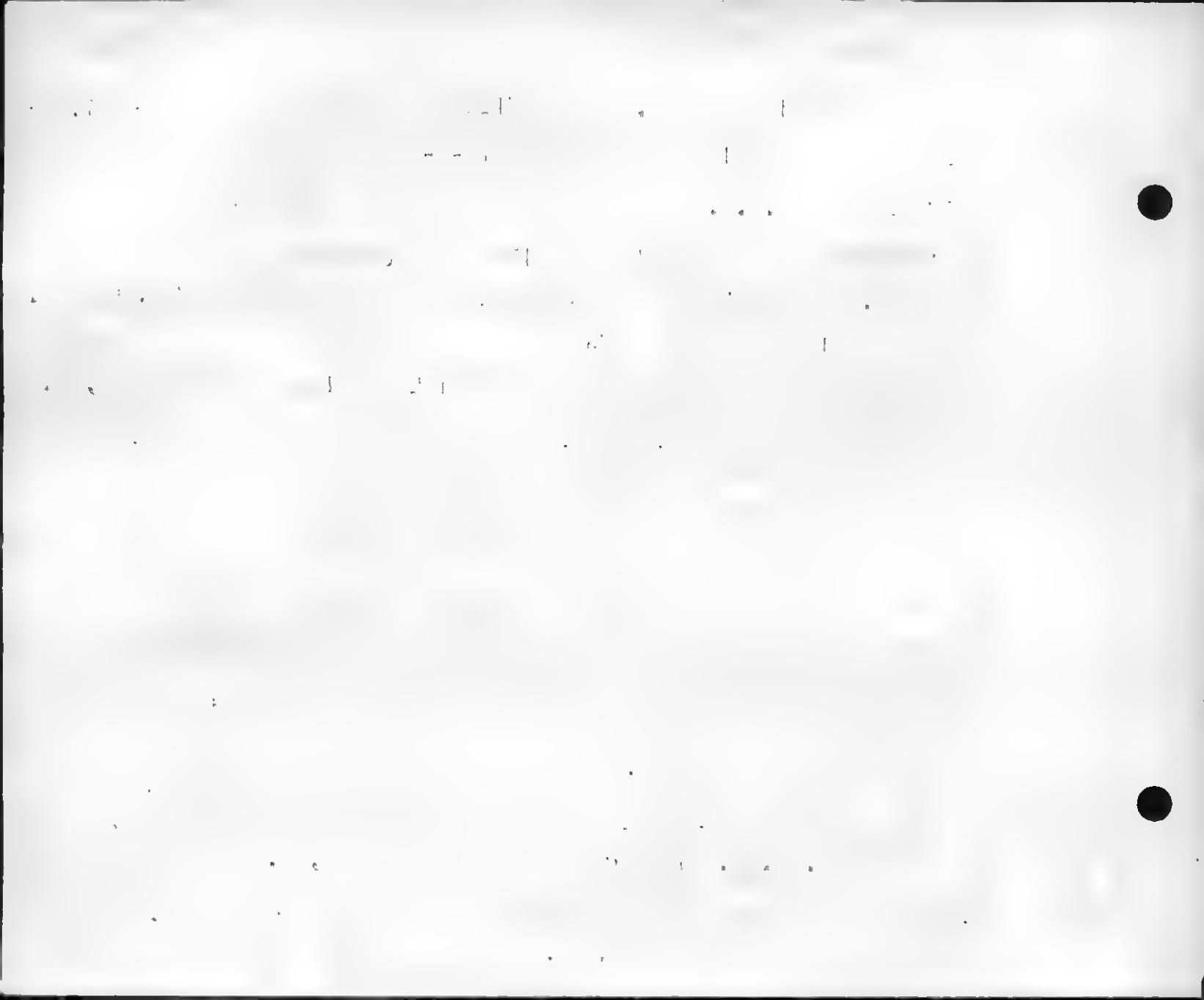
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 2 should be detached for use as the burial-transit permit. If either, notify medical examiner. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First BESSIE	Middle P.	Last MILLER	2a. DATE OF DEATH Month 12	Day 28	Year 68	2b. HOUR 1:45 PM	
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 11-2-91			6 AGE (In years last birthday) 77		IF UNDER 1 YEAR MONTHS YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 25 PENNSYLVANIA AVE.	
14. FATHER'S NAME First DAVID		Middle S	Last MANN	15. MOTHER'S MAIDEN NAME First MARY		Middle E	Last CREEK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Caecum - 1.400 cc.</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>188X</i></p> <p>(b) DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1810</i></p>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/2/68</i> , to <i>11/28/68</i> , that (I) (we) last saw the deceased alive on <i>11/26/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>DR. W. A. HIMMLER</i>		22c. DEGREE <i>DR. W. A. HIMMLER</i>		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED <i>11/28/68</i>		
23a. BURIAL, CREMATION, BURIAL REMOVAL (Specify)		23b. DATE Dec. 31, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		23d. LOCATION (City or Town) Near Artemas, Pa.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retumed by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16761

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)	First JOHN	Middle M. (ROY)	Last MINKE	2d. DATE OF DEATH 1 Month 9 Day 68 Year	2b. HOUR 2:55 P M
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 8-27-03		6 AGE (in years last birthday) 65 YRS.	F UNDER 1 YEAR MONTHS DAYS HOURS M.M.
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10 CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SWIMMING POOL OWNER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT. #4, BOX 405	Md.
14 FATHER'S NAME First (MIKE) MICHAEL J.	Middle MINKE	15. MOTHER'S MAIDEN NAME First ELIZABETH	Middle MINKE	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 214-32-3457	17 INFORMANT HOSPITAL RECORDS	SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Whispered, met to like, malignant</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1729 (b) <i>metasarcosis</i> DUE TO, OR AS A CONSEQUENCE OF lost. (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 mos.</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION Sept 6-7					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Same					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify med cal examiner)					
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					
21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968, to Dec. 1968, that (we) last saw the deceased alive on Sept. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) not view the body after death.					
22b. SIGNATURE <i>Miltenberger</i>					
22c. DATE SIGNED 11 Dec 68					
22d. PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER					
22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL CREMATION BURIAL					
23b. DATE Dec. 12, 1968					
23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery					
23d. LOCATION (City or Town) Cumberland, Allegany, Md. (County) (State)					
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME					
ADDRESS 108 VA. AVE CUMBERLAND, MD.					
25a. REC'D BY REGISTRAR DEC 16 1968					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

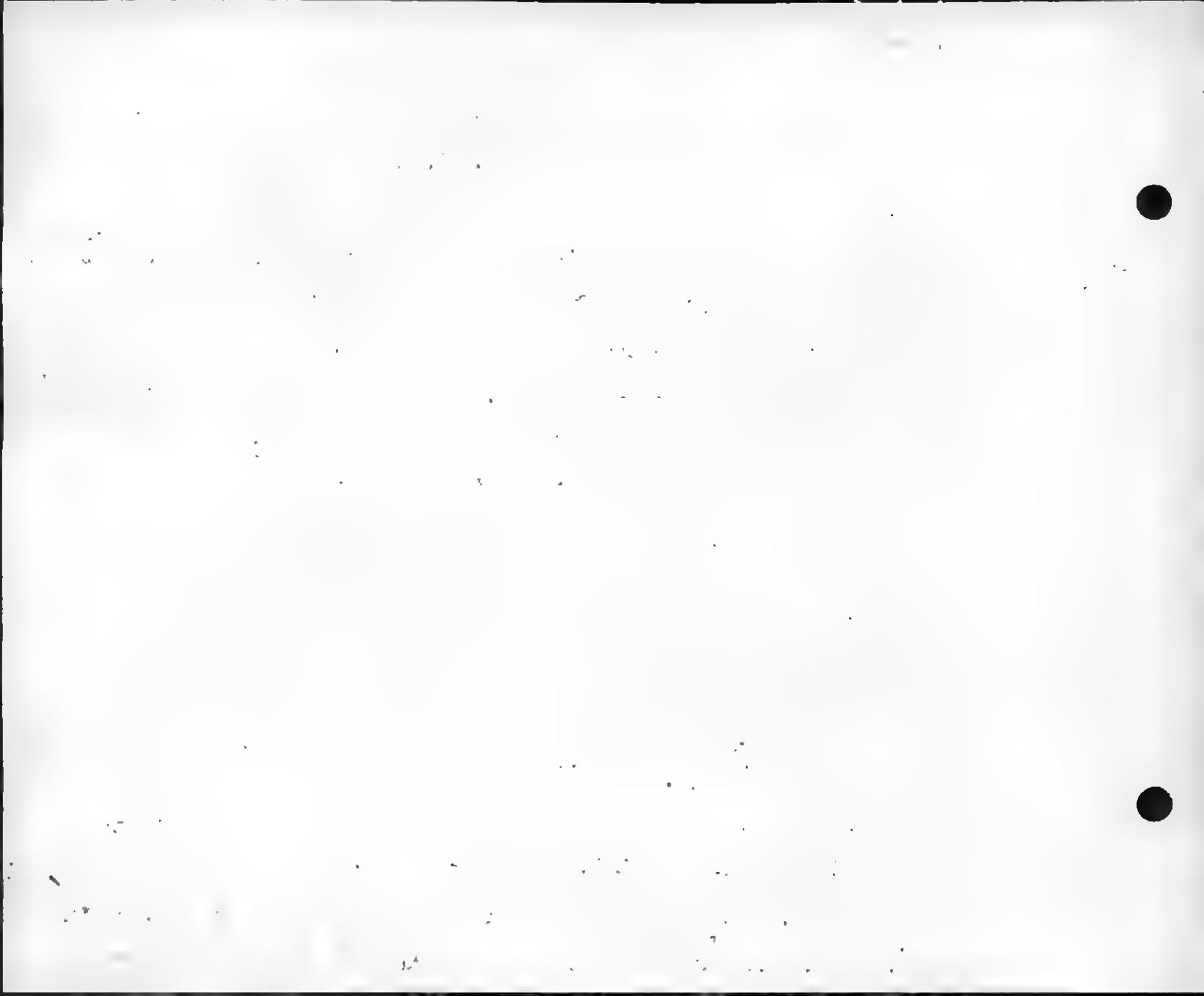
16749

16762

CERTIFICATE OF DEATH

1
 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician,
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.
 pages and
 shoulde be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED: NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR				
				William	Farnest	Mooney	Month	Day	Year	AM PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		White		Nov. 27, 1893			75 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
Ohio		U.S.A.					Allegany			12b. TRADE OR BUSINESS OF INDUSTRY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
Frostburg			Miners Hospital			Retired Mill Rite			Copperweld Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland				Allegany		Frostburg				94. Frost Village				
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
				George		Mooney				Ida		Kyle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			Address				
Yes				W.W. 2			Mrs. Katherine Mooney			Frostburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4120</u> <u>24 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral atherosclerosis</u> <u>6 yr.</u> due to, or as a consequence of stating the underlying cause (c) <u>Hypertensive cardiovascular disease</u> <u>25 yr.</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>														
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
		1965		Carcinoma of cecum			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING (□ OR CONTRIBUTING □ CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.			City or Town		County	State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 14, 1968</u> , to <u>Dec 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Alvin J. Walters MD</u> DEGREE ATTENDING PHYS MED. DIRECTOR STAFF PHYS DATE SIGNED <u>12/17/68</u>														
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			<u>48 Broadway Frostburg, Md.</u>									
Alvin J. Walters, M. D.														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)		(State)			
Burial		Dec. 18, 1968		Sunset Memorial Park			Near Cumberland		Alleg		Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<u>John J. Hafer, Jr.</u>		230 Balto Ave. Cumberland			DEC 20 1968		<u>Charles Judge</u>							
VR A15 (4) 30M REV. 1/68														



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16750

CERTIFICATE OF DEATH

16763

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time the physician or attending physician, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First		Middle	Last	2d DATE OF DEATH 12 Month 19 Day 68 Year	2b HOUR 7:00PM
MARY	LOU		MORT			
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH 06-25-27			6 AGE (In years at birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? US OF A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH ALLEGANY		
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived at admission) MARYLAND	f institution Residence before admision	13c CITY OR TOWN FROSTBURG	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 104 FROST AVENUE		
13b COUNTY ALLEGANY						
14 FATHER'S NAME JOHN S.	MIDDLE PRITCHARD	LAST	15 MOTHER'S MAIDEN NAME ORR MARY	MIDDLE PRITCHARD	LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b SOCIAL SECURITY NO 298-03-6360	17 INFORMANT SACRED HEART HOSPITAL RECORDS	900 SECON nd DRIVE, CUMB, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Retropertitoneal Sarcoma with Generalized abdominal + left pleural metastases</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1580 (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, not by med cert examiner)		21b TIME OF INJURY HOUR AM Month Day Year PM 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or RFD No	City or Town	County	State	
22a I certify that (I) (this hospital) attended the deceased from 12-16 , 19 68 , to 12-19 , 19 68 , that (I) (we) last saw the deceased alive on 12-19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>Andrew Stasko M.D.</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c DATE SIGNED 12-19-68			
22d PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.	22e ADDRESS 401 DECATUR ST., CUMBERLAND, MD.					
23a BURIAL, CREMATON, REMOVAL (Specify) BURIAL	23b DATE 12-19-68	23c NAME OF CEMETERY OR CREMATORIAL HAFER FUNERAL HOME Memorial Park	23d LOCATION (City or Town) FROSTBURG, ALLEGANY, MD.	(County) ALLEGANY	(State) MARYLAND	
24 FUNERAL DIRECTOR <i>John J. Hafer</i>	ADDRESS Frostburg	25a. RECD BY REGISTRAR DEC 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 45M						

T U

L E

Y

T T T

J U

T T

V J

V

Y

O T I

L

T T

C T C

C

T ^

T

U^ B C C + } = [

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this form. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												16764
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED			Month	Day	Year	2b HOUR
			MARY	JANE	MOWEN	<input checked="" type="checkbox"/>			Dec. 25, 1968	7	30am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR	
FEMALE	WHITE	JAN 16, 1886	82 YRS					December 25, 1968			7 30am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH						
RHODE ISLAND		USA		<input checked="" type="checkbox"/>	<input type="checkbox"/>	ALLEGANY						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
RFD# 2 FLINTSTONE MD.		AT HOME			HOUSEWIFE			HOUSEWIFE				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY (M) IS?		13e STREET AND NUMBER					
MARYLAND		ALLEGANY		RFD# 2 FLINTSTONE	<input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD# 2 BOX #153					
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last									
HENRY KIDD SPENCE			CATHERINE TODD									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT			ADDRESS			
NO			NONE			WILBERT L. MOWEN RFD# 2 FLINTSTONE MD. BOX 153						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CORONARY OCCLUSION												SUDDEN
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CORONARY SCLEROSIS												
--- DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420 i												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
22 d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED December 25, 1968				
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Cumberland, Maryland						
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b DATE 28 DEC 68		23c NAME OF CEMETERY OR CREMATORIUM PLEASANT GROVE CEMETERY		23d LOCATION (City or Town) RFD# 2 FLINTSTONE ALLEGANY MD		(County) (State)				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REG STRR'S SIGNATURE						
H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MD. DATE DEC 27 1968 <i>Charles Judge</i>												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16765

16752

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon papers. Poge 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Poge 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First CLARENCE	Middle E.	Last NEILSON	2d. DATE OF DEATH Month 12 Day 29 Year 68	2b. HOUR 5:08AM			
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 12-24-29		6 AGE (In years last birthday) 39 YRS	7 IF UNDER 24 HRS MONTHS 0	8 IF UNDER 24 HRS DAYS 0	9 IF UNDER 24 HRS HOURS 0	10 MIN 0	
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during working life, even if retired) FOREMAN		12b WORKING BUSINESS OR INDUSTRY PAPER MILL				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER RT. 1, BOX 107 B					
14 FATHER'S NAME MARSHALL	First MARSHALL	Middle NEILSON	Last NEILSON	15. MOTHER'S MAIDEN NAME SARAH	Middle WELLINGS	Last WELLINGS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No	16b. SOCIAL SECURITY NO. 213-22-2811	17 INFORMANT HOSPITAL RECORD		Address 900 SETON DR., CUMBERLAND, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		NEPHROSCLEROSIS							
(b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from JUNA , 19 68 , to 12-29 , 19 68 , that (I) (we) last saw the deceased alive on 12-28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.									
22b. SIGNATURE <i>L. Michael Glick</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-29-68				
22d. PHYSICIAN'S NAME (Type) MICHAEL GLICK, M. D.		22e ADDRESS SETON DR., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE 1/1/1969	23c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery		23d. LOCATION (City or Town) Moscow	(County) A.	(State) Md.		
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME		ADDRESS 8 E. MAIN ST., BETHESDA, MD. 20814	25a. RECD BY REGISTRAR 1969						
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

281

T

J

H

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper copies and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										16766
1 DECEASED NAME (Type or print)		First JOHN	Middle W.	Lost NELSON	2d. DATE OF DEATH Month 12			Day 26	Year 68	26. HOUR 6:40 AM
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-3-89			6 AGE (In years last birthday) 79 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md
10. CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BARBER			12b KIND OF BUSINESS OR INDUSTRY BARBER		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER COLUMBIA ST. 434 COLUMBIA ST.		
14 FATHER'S NAME First WILLIAM		Middle NELSON	Lost	15 MOTHER'S MAIDEN NAME First MARGARET			Middle			Lost KELLY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO 214-32-3384		17 INFORMANT PTS. HOSP CHART SACRED HEART HOSPITAL			Address 900 SETON DRIVE CUMBERLAND, MD. 21502			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause acute coronary occlusion		DUE TO, OR AS A CONSEQUENCE OF (b) coronary sclerosis			DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis			3 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none										2 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County	State	
22a I certify that (I) (this hospital) attended the deceased from 11-16-68 , to 12-26-68 , that (I) (we) last saw the deceased alive on 12-25-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE L Lewis Brings		DEGREE ATTENDING PHYS	22c. DATE SIGNED 12-26-68							
22d PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22e. ADDRESS 57 GREENE ST. CUMBERLAND, MD. 21502								
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/28/1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cath Cemetery		23d. LOCATION (City or Town) Cumberland		(County) Alleg	(State) Md	
24. FUNERAL DIRECTOR John J. Hafer Jr.		ADDRESS HAFER FUNERAL HOME 230 BALTO AVE. MD. 21503		25. REC'D BY REG STRR DEC 30 1968		26. REGISTRAR'S SIGNATURE Charles Judge				



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and intact, within 72 hours after death.

16754

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16767

1. DECEASED-NAME (Type or print)	First REGINALD	Middle JOSEPH	Last O'CONNOR	2a. DATE OF DEATH 12 Month 14 Day 68 Year	2b. HOUR 12:05
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 9-6-96	6. AGE (in years lost birthday) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? US OF A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY CO.	Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if part time) RETIRED FROM E.L.WALSH-TRUCK DRIVER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN MT. SAVAGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First JOHN	Middle O'CONNOR	15. MOTHER'S MAIDEN NAME First SHAFFER	Middle NORA.	Last E.	O'CONNOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> (If yes give war or dates of service) YES <input type="checkbox"/> KW-1	16b. SOCIAL SECURITY NO. 218-16-4882	17. INFORMANT HOSPITAL RECORDS	SACRED HEART HOSPITAL 900 SETON DRIVE., CUMB., MD.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120 Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF ARTERTIOSCLEROTIC AND HYPERTENSIVE CVD (b) DUE TO, OR AS A CONSEQUENCE OF (c)			2 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443.					
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased 12 - 14, 1968, to 12 - 14, 1958, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. W. BALLIN, M.D.	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-14-68	
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.	22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE 12-16-1968	23c. NAME OF CEMETERY OR CREMATORIUM ST. PATRICKS	23d. LOCATION (City or Town) MT. SAVAGE	(County) ALLEG. CO.	(State) MD.
24. FUNERAL DIRECTOR Joseph K. Surr, Frostburg, Md.	ADDRESS	25a. REC'D BY REGISTRAR DEC 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A1 30M REV. 7-68					

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

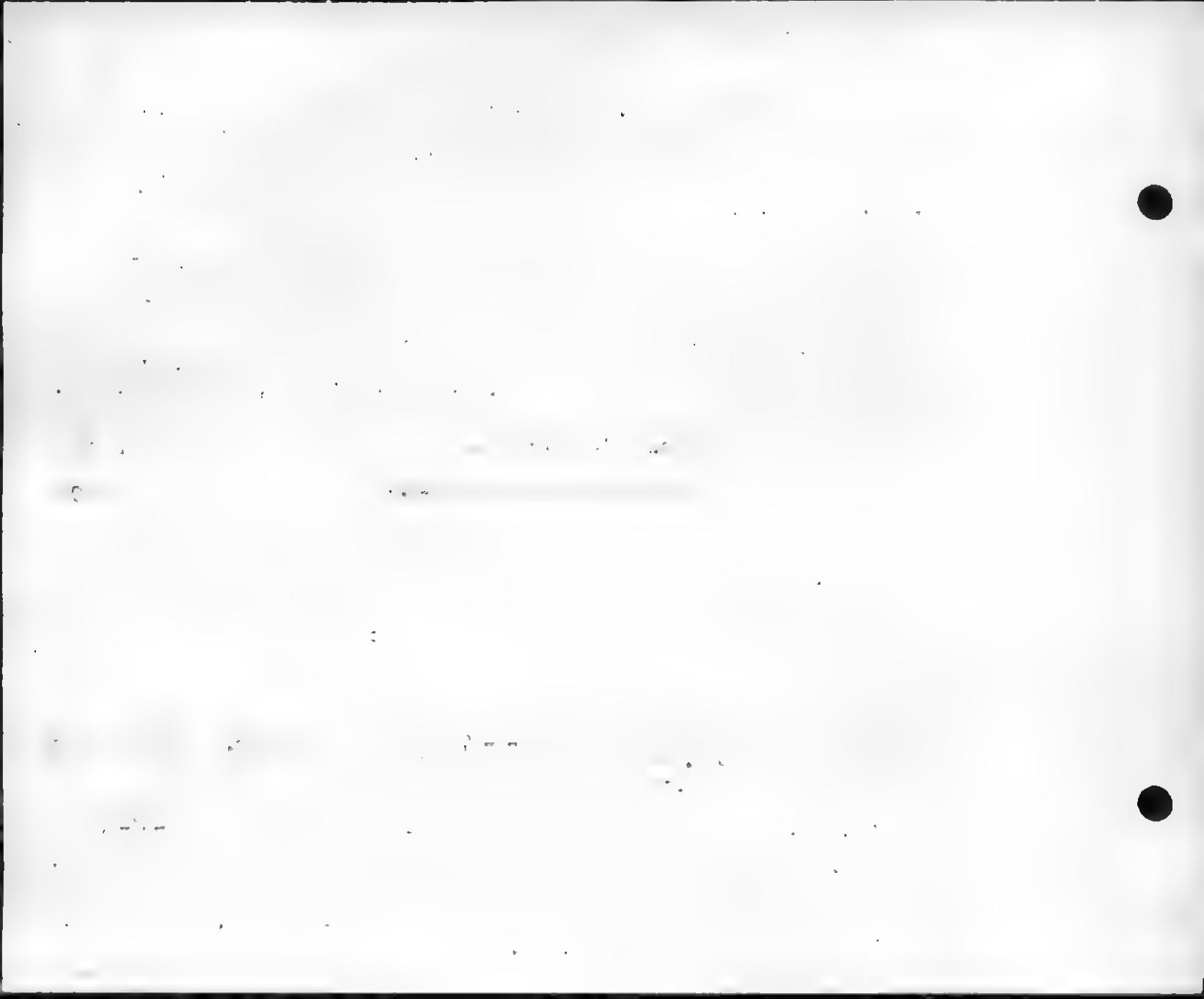
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16755

16768

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Maggie	Middle M.	Last Orndorff	2a DATE OF DEATH Dec. Month 24 Day Year 1968 - 5:50 P.M.	2b. HOUR P
3 SEX Female		4. RACE White		S. DATE OF BIRTH April 12, 1890	6. AGE (In years Last birthday) 78-78 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany	
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 134 Potomac St.	
14. FATHER'S NAME John R. Donaldson				15. MOTHER'S MAIDEN NAME Effie Mercer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17 INFORMANT Mrs. Elizabeth Malone, Cumberland, Md.	Address Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1966
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>AdenoCarcinoma of the Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c)				1959
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
1/2x Arteriosclerotic Cardiovascular Disease						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4-57</u> , 19 <u>68</u> , to <u>Dec. 24, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <u>Dr. G. Overton Himmelwright MD</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c DATE SIGNED 12-31-68	
22d. PHYSICIAN'S NAME (Type) Dr. G. Overton Himmelwright		22e. ADDRESS 133 Virginia Ave., Cumberland, Md.				
23a BURIAL CREMATION, BURIAL REMOVAL (Specify) Burial		23b DATE Dec. 28, 1968	23c NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d LOCATION (City or Town) Cumberland, Allegany, Md.	(County) (State)
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
			DATE JAN 6 1969			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 8 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Service along with farm PM3. Page 5 may be retained for your files.

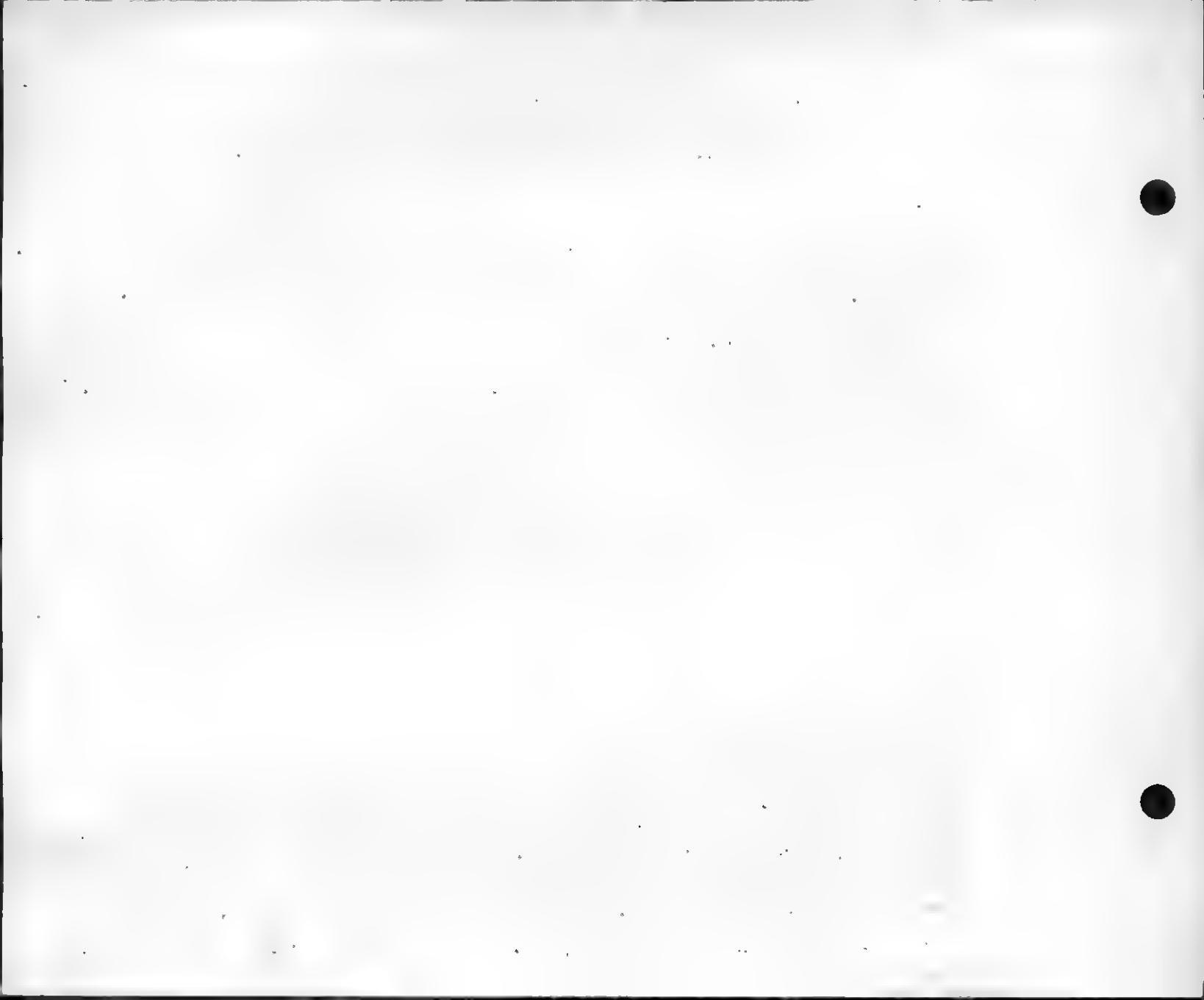
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages Tand2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16769

1 DECEASED NAME (Type or Print)		First WOODROW	Middle W.	Last OSBOURNE	2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 26 1968	Month Day Year 2d HOUR 2d HOUR 2d HOUR
3 SEX Male	4 RACE White	5 DATE OF BIRTH May 30, 1915	6 AGE (in years as of birthday) 53 yrs.	.7 UNDER 1 YEAR MONTHS GAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year Dec. 26 1968 3P M
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Allegany	
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 23 Virginia Ave.			12a LSLA. OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13c CITY OR TOWN Allegany		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 23 Virginia Ave.	
14 FATHER'S NAME Milton		Middle E. Osbourne	Last Osbourne	S. MOTHER'S MAIDEN NAME Florence	Middle S. Wharton	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b SOCIAL SECURITY NO War II		17 INFORMANT Mts. Agatha Osbourne, Cumberland, Md.-Wife		ADDRESS
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I - DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CORONARY OCCLUSION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		CORONARY THROMBOSIS				11
DUE TO, OR AS A CONSEQUENCE OF (b)		CORONARY SCLEROSIS				----
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 9		2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
2d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building etc.)		2f LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 26, 1968 ADDRESS (Street, city, town, or county) Rt. 9, Cumberland				
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE Dec. 29, 1968	23c NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d LOCATION (City or Town) ((County)) (State) Cumberland, Md. Allegany	
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a REC'D BY REGISTRAR DATE JAN 3 1969	25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16770

CERTIFICATE OF DEATH

16757

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First BURLEY	Middle NM	Last PENNINGTON	2a DATE OF DEATH Month 12	Doy 24	Year 68	2b HOUR P 11:55
3 SEX MALE	4. RACE WHITE	5 DATE OF BIRTH 03-08-92			6. AGE (In years last birthday) 76	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY,			
10. CITY OR TOWN OF DEATH CUMBERLAND,		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital) give street address SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret red) COOK		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN CUMBERLAND	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 225 BALTIMORE STREET				
14. FATHER'S NAME First NATHANIEL	Middle J.	Last BENNINGTON	15 MOTHER'S MAIDEN NAME First (LUCRETIA)	Middle PENNINGTON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b SOCIAL SECURITY NO 215-20-6160	17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	Address MD. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS			
4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					CORONARY HEART DISEASE 3 YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12 - 16, 1968 , to 12 - 24, 1968 , that (I) (we) last saw the deceased alive on 12 - 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>R.W. Ballin</i>		DEGREE PHYS	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-25-68		
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22e ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502						
23a BURIAL, CREMATION, APPROVAL (Specify)		23b DATE 12/28/68	23c NAME OF CEMETERY OR CREMATORIAL Pleasant Grove			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany MD		
24. FUNERAL DIRECTOR <i>James Stein Inc</i>		ADDRESS STEIN FUNERAL HOME, 117 FREDERICK ST., CITY	25a REC'D BY REGISTRAR DEC 31 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

7 21

1 21

2 21

2 21

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16758

CERTIFICATE OF DEATH

16771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First LOUISE	Middle M.	Last PLUMMER	2a. DATE OF DEATH Month 12 Day 25 Year 68	2b. HOUR 7:55A M
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 10-19-15		6 AGE (in years 55 birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give SACRED) HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during last year of life, if applicable) MANUFACTURER		12b KIND OF BUSINESS OR INDUSTRY INDUSTRIES CO.	
13a USUAL RESIDENCE (Where deceased lived if institution Residenc before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY, M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER SUSANNA ST.		
14 FATHER'S NAME First WILLIAM	Middle S.	Last PLUMMER	15 MOTHER'S MAIDEN NAME First ANNE	Middle MAE	Last WAGONER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input type="checkbox"/> unknown	16b SOCIAL SECURITY NO 217-10-4162		17 INFORMANT HOSPITAL RECORD, 900 SETON DR., CUMB., MD. Address			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) stroke APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hypertension (c) arteriosclerosis, old stroke 1 year 2 yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 12/14/68 , to 12-25-68 , that (I) (we) last saw the deceased alive on 12-24-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>L. Brings</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-25-68	
22a. PHYSICIAN'S NAME (Type) LEWIS BRINGS M.D.		22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL HOSPITAL		23d. LOCATION (City or Town) FROSTBURG, MD.	(County)	(State)
24. FUNERAL DIRECTOR DURST FUNERAL HOME	ADDRESS FROSTBURG, MD. 21532		25a. REC'D. BY REC. STAR DATE DEC 31 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in Item 18 Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM3. Page
5 may be retained for your files.

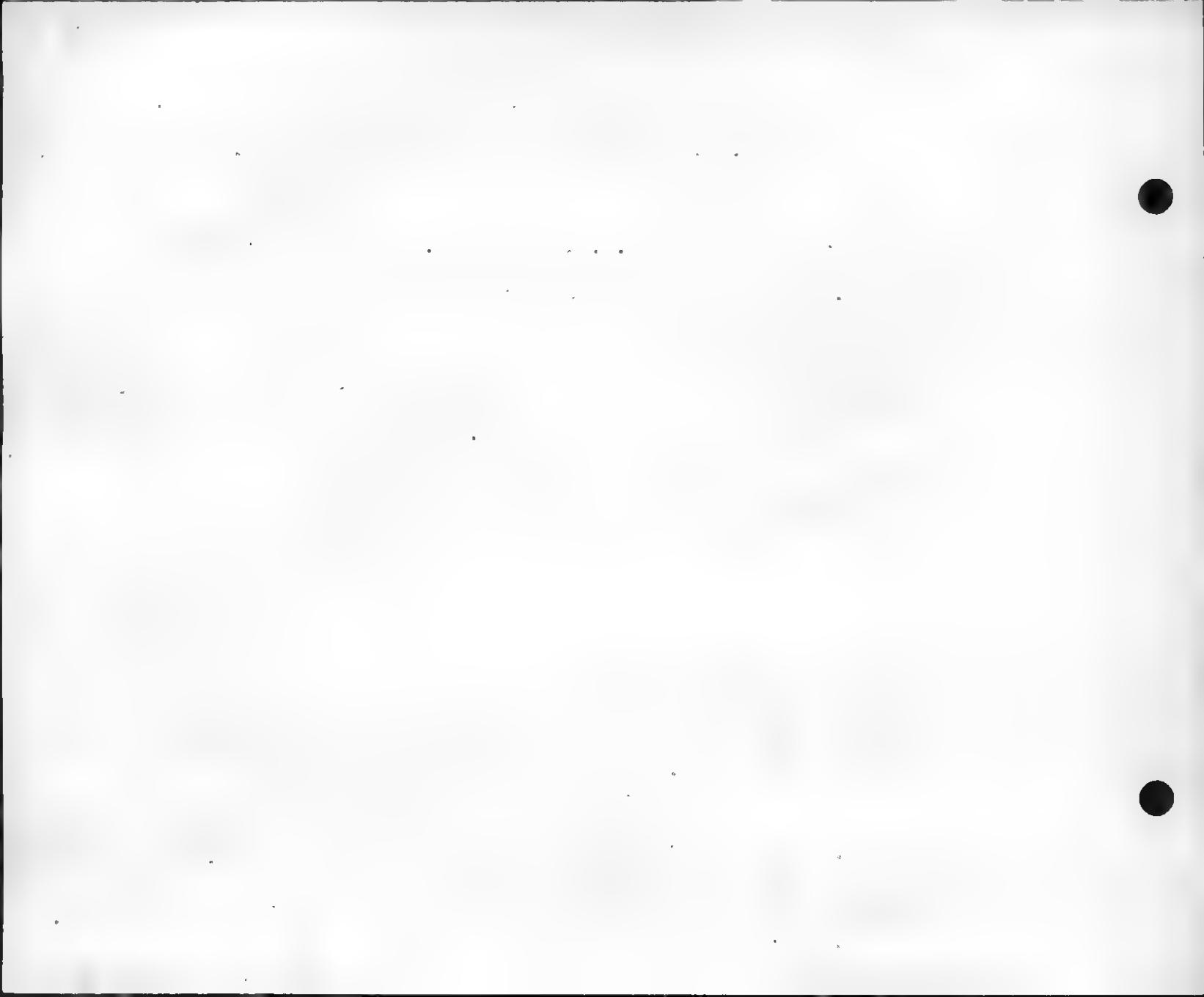
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and any event within 72 hours after death.

16759

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16772

1. DECEASED NAME (Type or Print)		First Maurice	Middle Winfield	Last Rice	20. DATE KNOWN OF ESTI. DEATH MATED	Month Dec. 26	Day 19	Year 68	2b. HOUR 8P M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 6, 1892	6. AGE (In years on birthday) 76 YRS	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS HOURS 0	9. COUNTY OF DEATH Allegany	2c. DATE PRONOUNCED DEAD Month Dec. 26	Day 19	Year 68	2d. HOUR 8P M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED W DOWED <input checked="" type="checkbox"/>		NEVER MARRIED D. VORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, if retired)		12b. KIND OF BUSINESS OR INDUSTRY Retired Boilermaker Railroad					
13a. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY, J.M.T.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15 Laing Ave.			
14. FATHER'S NAME First Scott		Middle Rice	Last	15. MOTHER'S MAIDEN NAME First Unknown		Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give name or dates of service)		17. INFORMANT		ADDRESS					
				Mr. Quentin Rice, Cumberland, Md.-Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CORONARY THROMBOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN											
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS ----- (c) ----- DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>Benedict Skitarelic</i> Dr. Benedict Skitarelic MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.		22b. DATE SIGNED December 26, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 29, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR Date JAN 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



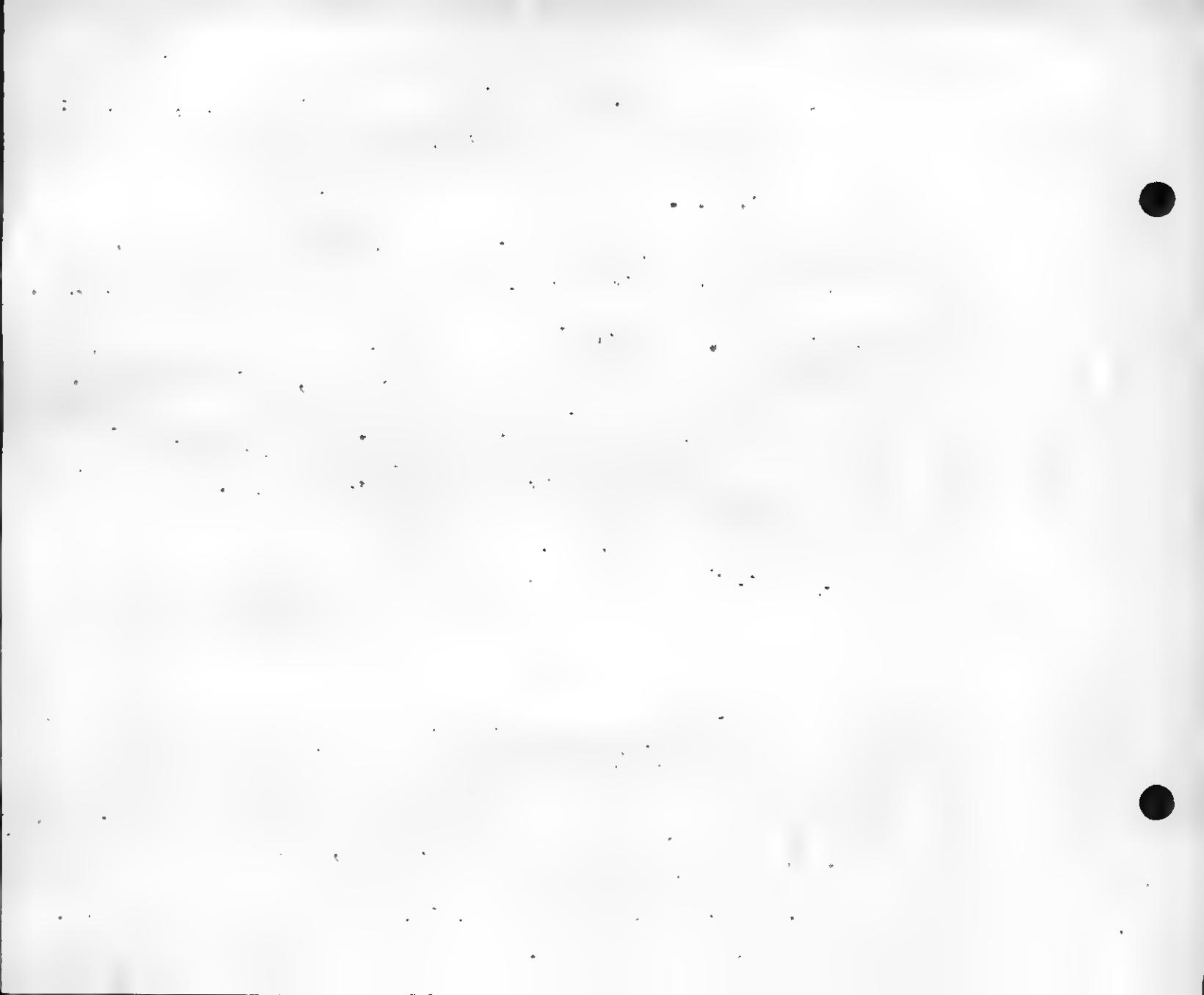
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16773

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have a director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First GERALD	Middle C.	Last RILEY	2d. DATE OF DEATH Month DECEMBER	2d. HOUR Day 28, 1968	2d. HOUR Min 4:35 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1-7-1901		6. AGE (in years (in months) 67) YRS.	F. UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during past of working life even if retired) PART-TIME MACHINE		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1101 LAFAYETTE AVE.			
14. FATHER'S NAME First JAMES	Middle C.	Last RILEY	15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Thrombosis (cardiogenic shock) due to disease of Arterio Sclerotic heart disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) Due to, or as a consequence of Arterio Sclerotic cerebrovascular disease							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Arterio Sclerotic cerebrovascular disease							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town Cumberlnd of Allegany, Md.	County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/27/68 , 19, to 12/28/68 , 19, that (I) (we) last saw the deceased alive on 12/27/68 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. J. Williams							
22c. PHYSICIAN'S NAME (Type) R. J. WILLIAMS	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 12/29/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 31, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS		25a. REG'D BY REGISTRAR JAN 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 30M REV.	DATE		DATE				



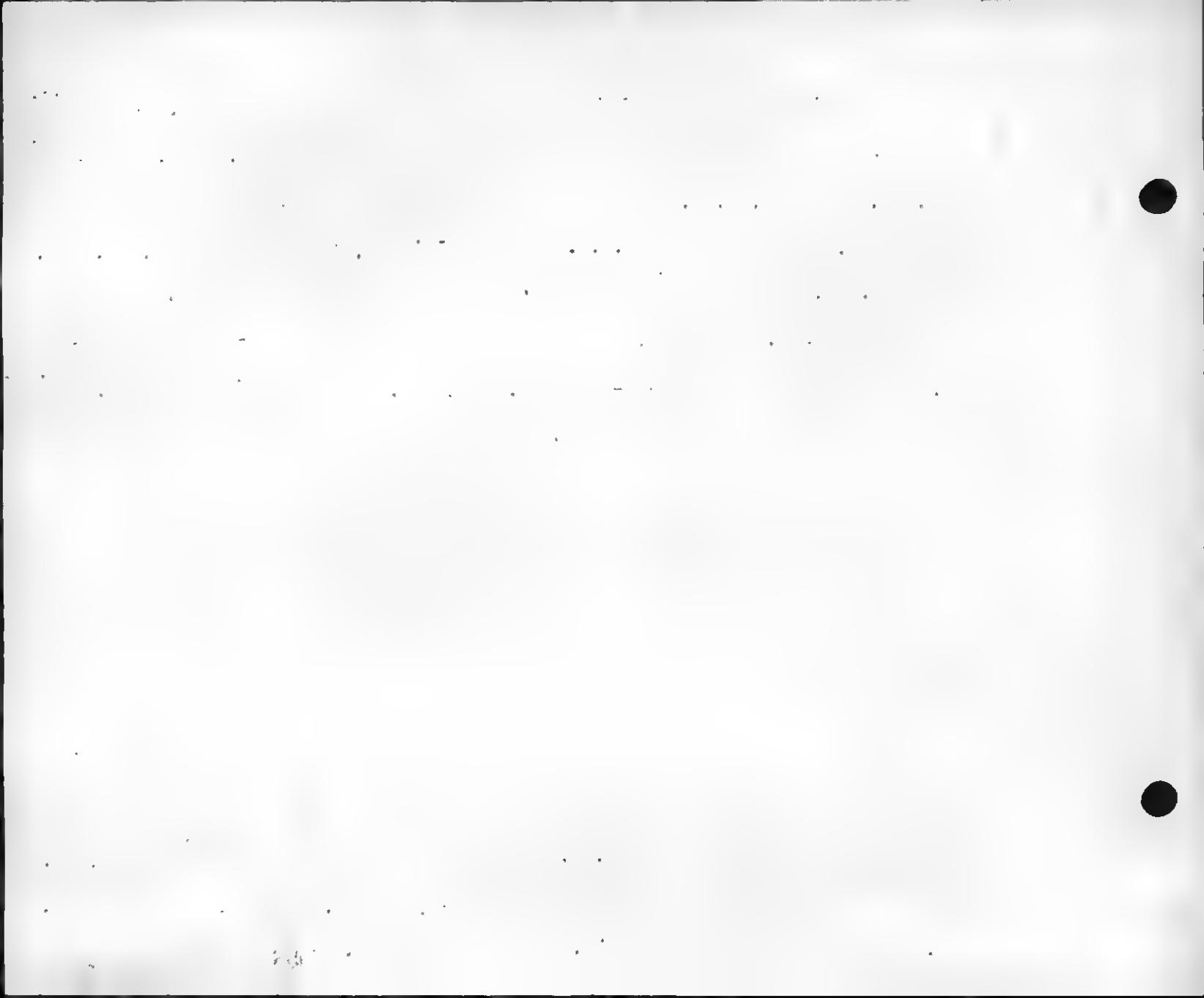
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												16774		
1. DECEASED NAME (Type or Print)			First <i>Stanley</i>	Middle <i>Gerant</i>	Last <i>Robertson</i>	20 DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 28, 1968			2B HOUR 10 p.m.					
3 SEX <i>Male</i>	4 RACE <i>White</i>	S DATE OF BIRTH <i>June 19, 1900</i>	6 AGE (in years just birthday) <i>68 yrs</i>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>			2c DATE PRONOUNCED DEAD Month Day Year <i>Dec. 28, 1968</i>			2d HOUR 10 p.m.				
7a BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b C.T.ZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Allegany</i>			12b KIND OF BUSINESS OR INDUSTRY <i>W. Md. Ruy.</i>						
10 CITY OR TOWN OF DEATH <i>Cumberland,</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>D.O.A. Memorial</i>			12c J.SAL OCCUPAT ON (Kind of work done during most of working life, even if retired) <i>Ret. Foreman</i>			13b STREET AND NUMBER <i>39 Blocker St.</i>					
13a USJA & RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <i>W. Va.</i>			13c CITY OR TOWN <i>Ridgeley,</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <i>39 Blocker St.</i>					
14 FATHER'S NAME First <i>Charles N. Robertson,</i>			15 MOTHER'S MAIDEN NAME First <i>Viola</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown) <i>No</i>			16b SOC.A. SECURITY NO <i>705-10-7709</i>			17 INFORMANT <i>Mt. Lowell S. Robertson</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4109</i>			CORONARY OCCLUSION			ADDRESS <i>Ridgeley, W. VA.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>---</i>			(b)			DUE TO, OR AS A CONSEQUENCE OF <i>CORONARY SCLEROSIS</i>								
(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19c MEDICAL CERTIFICATION				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)										
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21d PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21e LOCATION Street or RFD No City or Town County State		
21f														
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b DATE SIGNED <i>12/28/68</i> Rt. 9		
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M. D.</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Cumberland, Md.</i>		
23a BURIA, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>12/31/68</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Greenridge Cemetery.</i>		23d LOCATION (City or Town) (County) (State) <i>nr. Oldtown, Allegany Md.</i>		25a REC'D BY REGISTRAR DATE <i>JAN 2 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
24 FUNERAL DIRECTOR <i>H. Wayne George</i>		ADDRESS <i>Cumberland, Md.</i>												



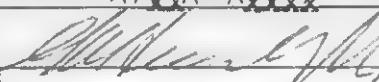
Item 18 Film 408 1-21-69a MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

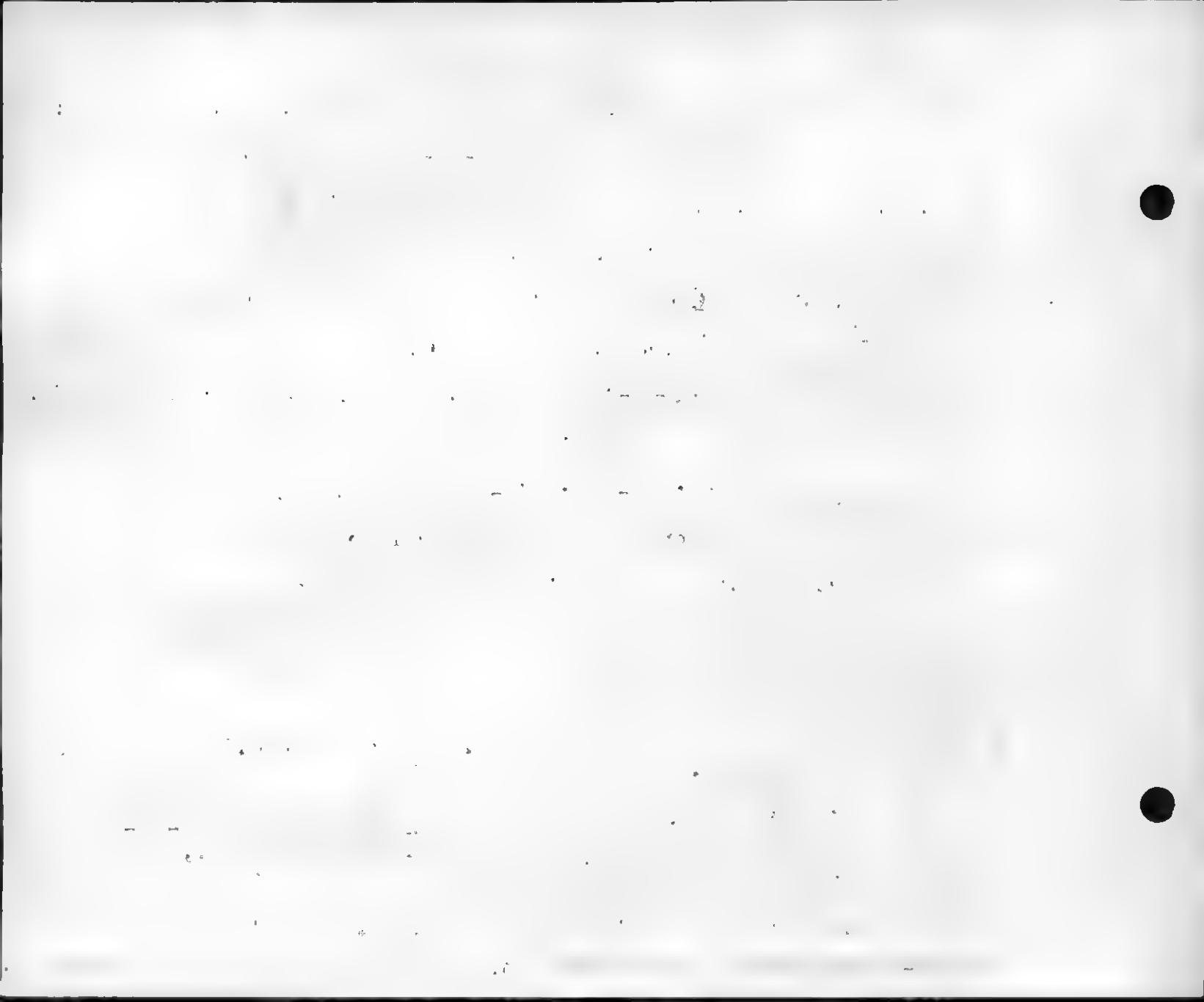
16762

16775

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7/2 hours after death.

1. DECEASED NAME (Type or print)	First PERSIS	Middle L.	Last ROBY	2a. DATE OF DEATH DECEMBER 18, 1968	2b. HOUR 8:35 PM
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 9-16-1897	6. AGE (In years last birthday) 71	IF UNDER 1 YEAR MONTHS YRS.	F. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. VA.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during month before if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if in hospital admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 403 LINDEN ST.	
14. FATHER'S NAME JOHN	First Middle SHROUT	15. MOTHER'S MAIDEN NAME LUCY	Middle HARTMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-50-0483	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septemias DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse-multiple-systemic myocotic abscesses DUE TO, OR AS A CONSEQUENCE OF Miliary tuberculosis - Active (c) Secondary to Acute Viral Infection					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) Arteriosclerotic Cardio-Vascular Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1968, to Dec. 18, 1968, that (I) (we) last saw the deceased alive on Dec. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death					
22b. SIGNATURE 		22c. DATE SIGNED 12-20-68			
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22e. ADDRESS 133 Virginia Ave., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/21/68	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland Allegany Maryland	(County)	(State)
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE DEC 23 1968 		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

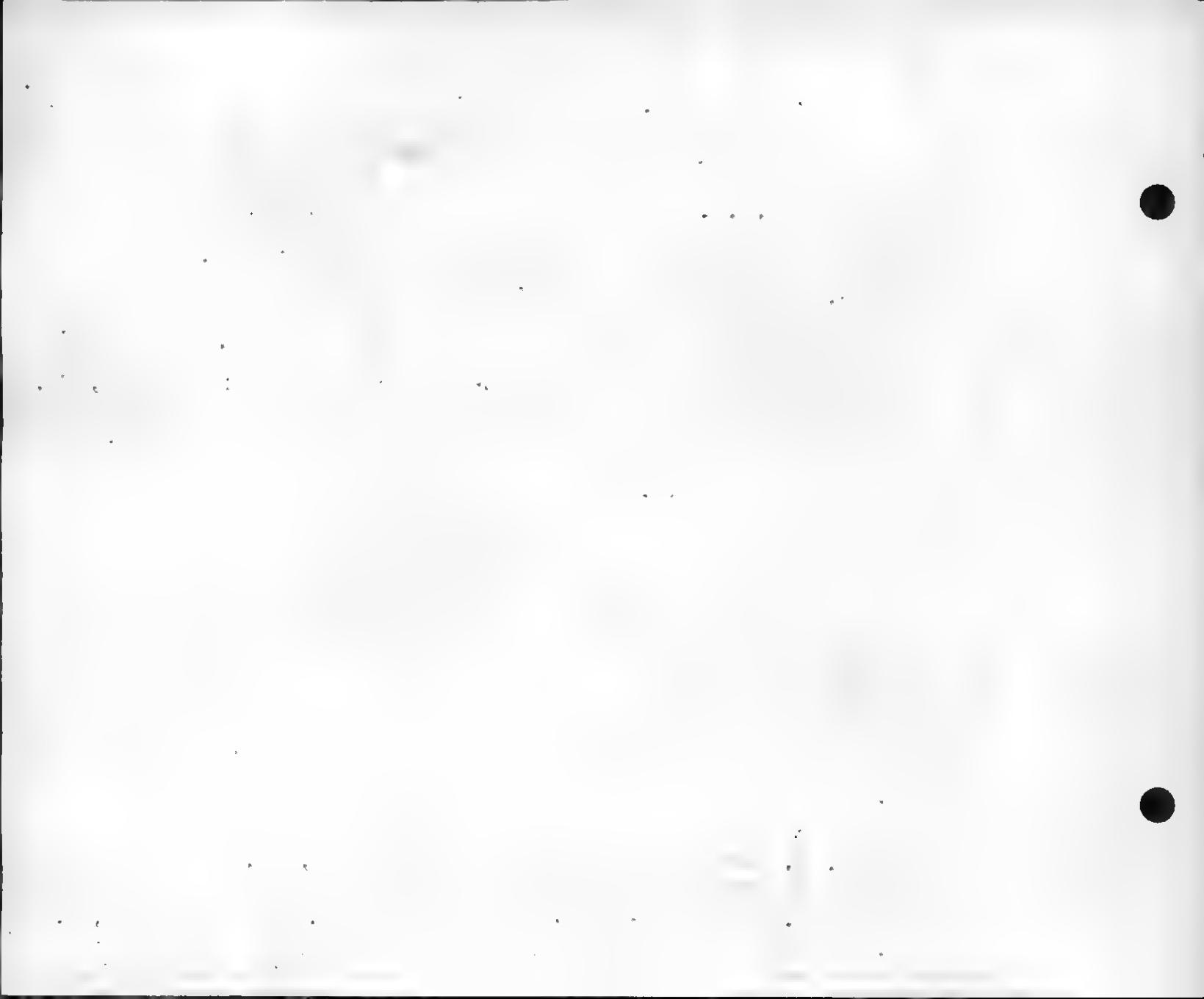
1
16763

CERTIFICATE OF DEATH

16776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First MARY	Middle M.	Last ROSS	2d. DATE OF DEATH Month 12	2d. HOUR 10:40			
3. SEX FEMALE		4 RACE WHITE	5. DATE OF BIRTH 9-27-1894		6. AGE (in years last birthday) 74	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS. MONTHS 0	9. IF UNDER 1 MIN. HOURS 0	10. HOURS A
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ALLEGANY				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance Dept.		12b. KIND OF BUSINESS OR INDUSTRY Tire			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) WEST VA.		13b. COUNTY	13c. CITY OR TOWN RIDGELEY	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
14. FATHER'S NAME First JOHN		Middle WAXLER	15. MOTHER'S MAIDEN NAME First MARY		Middle S.	Last LEASE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <i>lung cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lung cancer</i> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1952</i> to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>DR. B. SCHINDLER</i>		22c. DATE SIGNED <i>1/12/68</i>		22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATON, <input type="checkbox"/> BURIAL <input type="checkbox"/> Cremation		23b. DATE Dec. 26, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. RECD BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 30M REV. 1/68									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

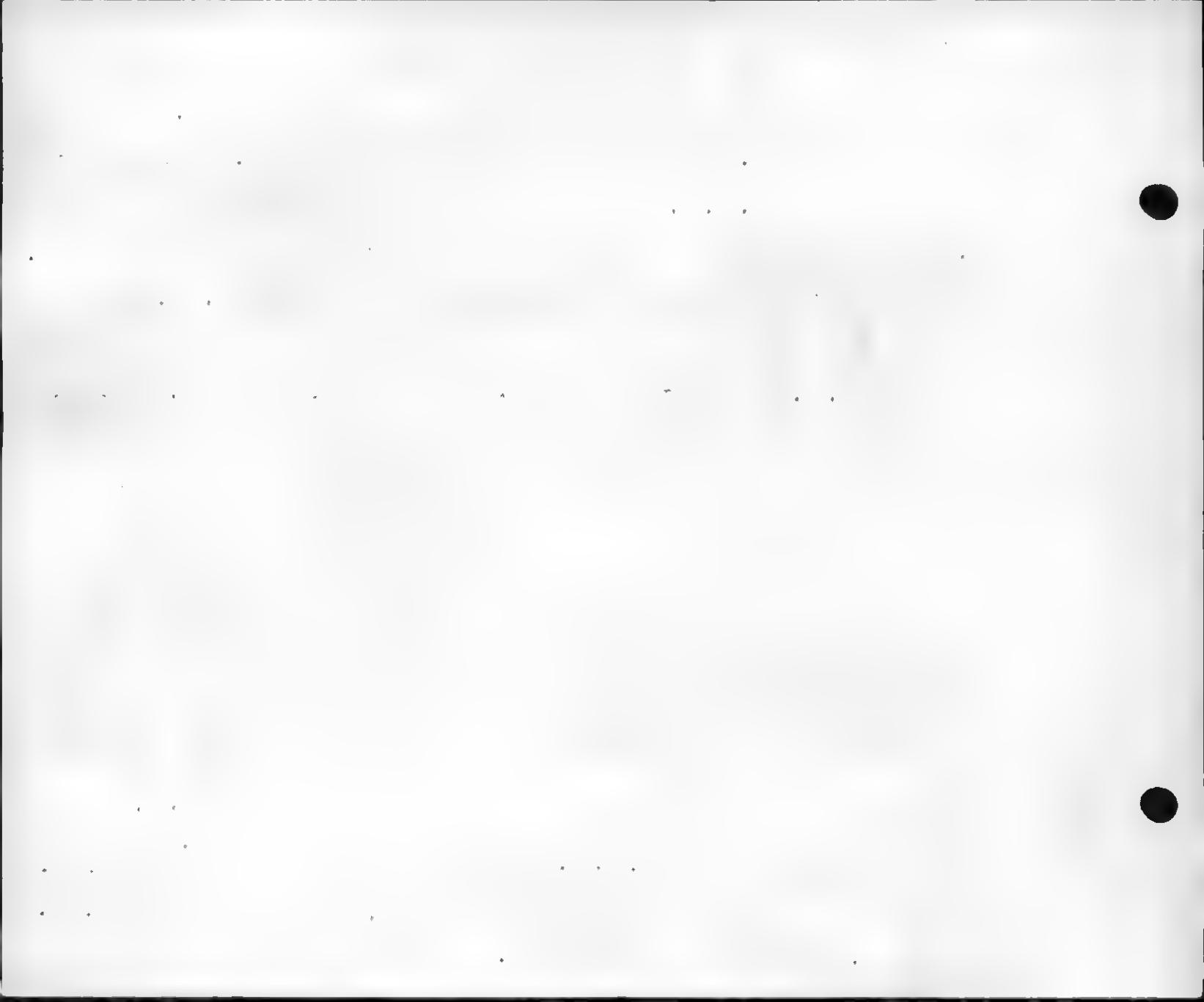
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16777

1 DECEASED NAME (Type or Print)	First John	Middle Thomas	Last Royer	2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/>	Month Dec.	Day 2	Year 1968	2b HOUR PM 7:00 M
3 SEX Male	4. RACE White	S. DATE OF BIRTH Apr. 27, 1910	6 AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Dec. Day 4 Year 1968		
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Rt. # 3 Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastman Road	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Orchard Wkr.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Allegany	13c CITY OR TOWN Cumberland	3d. INSIDE CITY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Eastman Rd. Rt. # 3				
14. FATHER'S NAME First John	Middle Thomas	Last Royer	15 MOTHER'S MAIDEN NAME Effie	First --	Middle --	Last Cowgill		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.	16b SOCIAL SECURITY NO. (If yes give year or dates of service) W. W. # 2	17. INFORMANT Mrs. Sylvia Wharton, 447 Seymour St., Cumb. Md.	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours					
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Cardiac Hypertrophy					
DUE TO, OR AS A CONSEQUENCE OF (c)			Myocardial Infarctions					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Sclerosis; Pulmonary Emphysema								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJRY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJRY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			Dec. 4 1968				
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED Rt. # 9				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
ADDRESS (Street, city, town, or county) Cumberland, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 12/6/68	23c. NAME OF CEMETERY OR CREMATORIUM Camp Hill Cemetery	23d LOCATION (City or Town) Pav Pav	(County) Morgan, W. Va.	(State)			
24 FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.	25a REC'D BY REGISTRAR DEC 9 1968	25b REGISTRAR'S S.G. SIGNATURE <i>Charles Judge</i>					





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

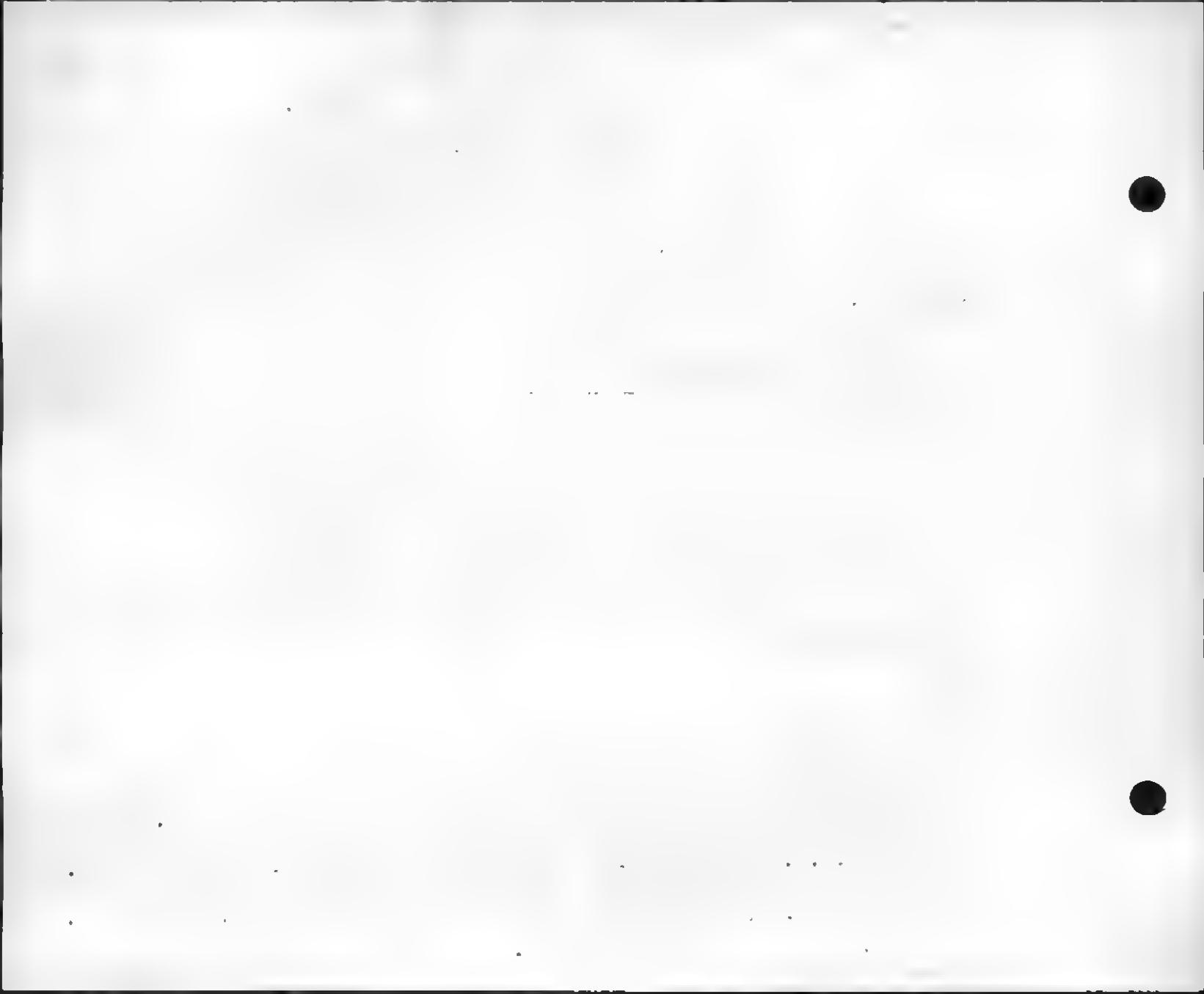
16766

16779

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~completely~~ filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Myrtle	Middle M	Last Smith	2d. DATE OF DEATH Dec. Month 22 Day 68 Year	2b. HOUR 950P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH 7-16-97		6 AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Cumberland	7b CITIZEN OF WHAT COUNTRY? Allegany	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Allegany		
10 CITY OR TOWN OF DEATH Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland and Nursing Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 601- Md.	13b COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES	13e STREET AND NUMBER 601 1/2 Hilltop Drive	
14 FATHER'S NAME First John	Middle O Neal	15. MOTHER'S MAIDEN NAME First Mary Ellen	Middle Mc Donaald	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-05-7210-A	17 INFORMANT Marie Lowery Daughter	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Concussion - cerebral -</i> 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
(b) <i>Accelerated - infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c)			3 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 154X					
19a. DATE OF OPERATION Aug. 1967	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED For recent conv.	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) at work	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) W.h.m. Not while at work			
21d. INJURY OCCURRED WHEN Not while at work	21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BLDG, ETC.) at home	21f LOCATION Street or R.F.D. No City or Town	County	State	
22a. I certify that (I) (his hospital) attended the deceased from August 1967 , to Dec. 26, 1968 , that (I) (we) last saw the deceased alive on Sept. 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) view the body after death.					
22b. SIGNATURE <i>Dr. R.W. Miltenberger</i>			22c. DATE SIGNED Dec. 30, 1968		
22d. PHYSICIAN'S NAME (Type or print) Dr. R.W. Miltenberger, MD	22e ADDRESS 122 S. Centre St., Cumberland, Md.				
23a. BURIAL, CREMATION, BURNING (Specify) Burial	23b. DATE Dec. 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County)	(State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. RECD. BY REGISTRAR JAN 2 1969	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jager</i>		
VR A15 30M REV 11-68		DATE			



16787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16780

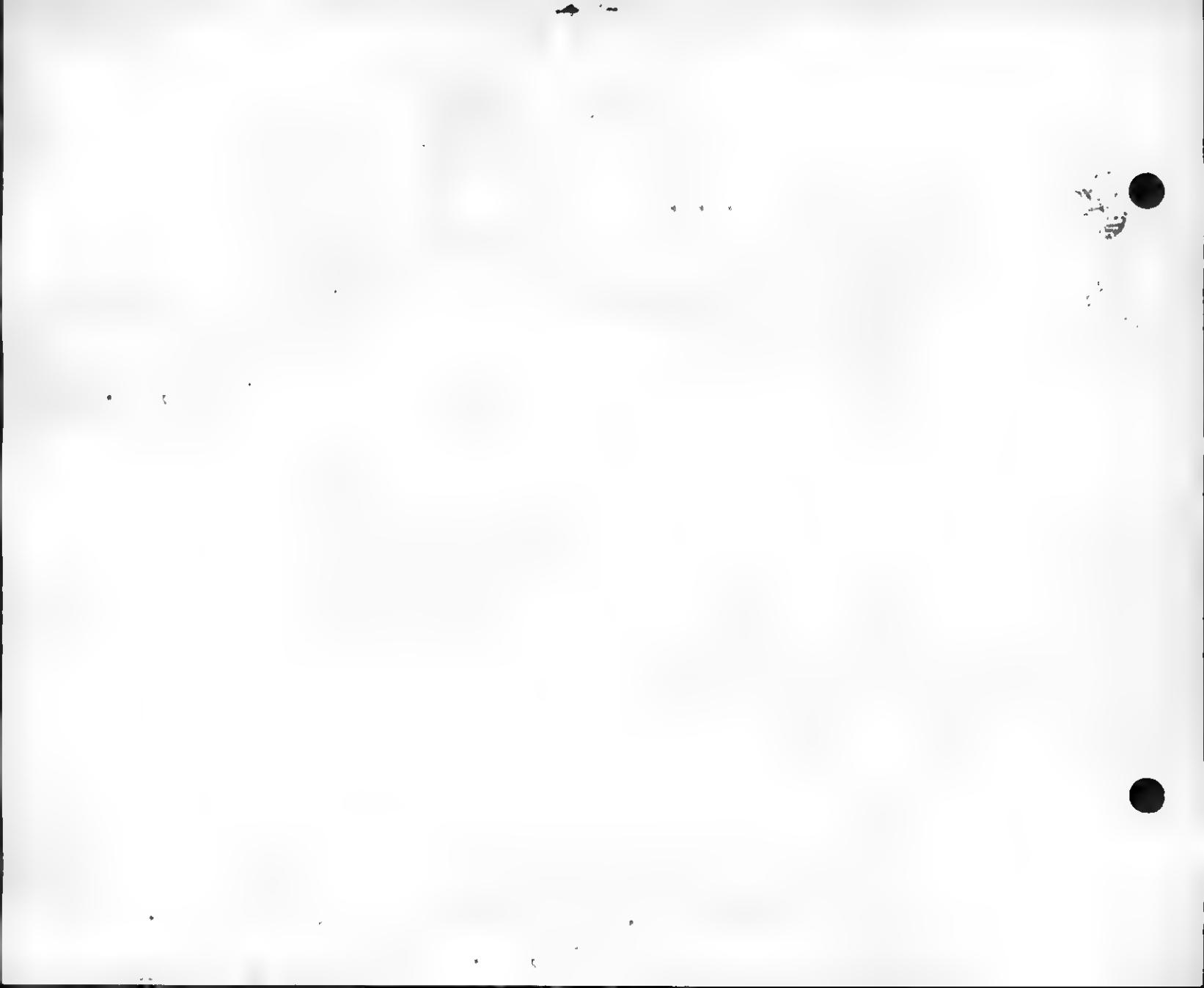
Item 3 Film G408 1/6/69 kk

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Florence	Middle Beckley	Last Snelson	2a. DATE OF DEATH Month 12	Day 24	Year 1968	2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2/21/1888			6. AGE (In years last birthday) 80	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Lonaconing	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kyle Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY Lonaconing Street 21542
13a. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Midland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Joseph	Middle Beckley	Lost	15. MOTHER'S MAIDEN NAME First Unknown	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT James Snelson			Address Midland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction			"Son"			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arterosclerosis						(years)	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Surgery							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec. 21 1968 , to Dec. 24, 1968 , that (I) (we) last saw the deceased alive on Dec. 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Florence Beckley		DEGREE <input checked="" type="checkbox"/> MED PHYS <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 12-24-68				
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22e. ADDRESS LONACONING MD 21539					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORIAL St. George Cemetery		23d. LOCATION (City or Town) Mt. Savage	(County) A.	(State) Md	
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. RECD BY REGISTRAR DEC 27 1968		25b. REG STAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16768

16781

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or print)		First JOHN	Middle T.	Last SPRIGGS	2a DATE OF DEATH Month 12 Day 28 Year 68	2b HOUR 10:30M
3 SEX XX MALE	4 RACE WHITE	5 DATE OF BIRTH 5-7-01		6 AGE (in years last birthday) 67 YRS	F UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 MRS. HOURS 0 MIN 0
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? US OF A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED MAIL CARRIER		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN FLINTSTONE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER None		
14 FATHER'S NAME First WILLIAM	Middle SPRIGGS	Last ??	15 MOTHER'S MAIDEN NAME First KATHERINE	Middle SPRIGGS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown XX YES	16b. SOC AL SECURITY NO (If yes give war or dates of service) 578-12-1843	17 INFORMANT SACRED HEART HOSP. RECORDS, CUMBERLAND, MD.	Address 800 SETON DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Secondary to vascular disease</i> BETWEEN ONSET AND DEATH (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 16 Dec 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal obstruction</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10 Dec., 1968 , to 23 Dec., 1968 , that (I) (we) last saw the deceased alive on 28 Dec., 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>R. Miltenberger, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 29 Dec. 68	
22d. PHYSICIAN'S NAME (Type) F. W. MILTENBERGER, M.D.		22e. ADDRESS 201 GRAND AVE., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, BURIER (Check only) Burial		23b. DATE Dec. 31, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County) Allegany	(State) Md.
24. FUNERAL DIRECTOR James F. Scarpelli		ADDRESS Cumberland, Md.	25a. RECD BY REGISTRAR DATE JAN 2 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

八

1

- 1 -

218

7

— 7 —

21

1

卷之三

卷之三

1

BRIEF REPORT

Digitized by srujanika@gmail.com

2

17

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First LENNIE	Middle M	Last STEELE	2a. DATE OF DEATH Month 12	Day 5	Year 68	2b. HOUR A 7:25 M		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 4-28-98			6. AGE (In years last birthday) 78	YRS.	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 M. M.N. 0	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MD.			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN LONACONING	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER BOX 31, STAR ROUTE						
14. FATHER'S NAME First WILLIAM	Middle PIPER	Last	15. MOTHER'S MAIDEN NAME First JENNIE	Middle	Last BILBEE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown 109	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal congestive heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months				
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> myocardial infarction, anterior cerebral & inferior						Early July 68				
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus, 11 + years						10 years				
DUE TO, OR AS A CONSEQUENCE OF (c) A. S. cordiorrose disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus, 11 + years										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 22 July, 1968 , to 5 Dec., 1968 , that (I) (we) last saw the deceased alive on 4 Dec., 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED Dec. 5, 1968
22b. SIGNATURE W. A. Van Ormer, M.D.		22c. DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.					
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/7/1968	23c. NAME OF CEMETERY OR CREMATORIAL Steele Cemetery			23d. LOCATION (City or Town) Lonaconing		(County) A.	(State) Md.		
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3 Page 5 may be retained for your files.
2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16783

1. DECEASED NAME (Type or Print)		First William	Middle Russell	Last Stewart	20. DATE KNOWN OF DEATH MATED	Month DEC.	Day 30	Year 1968	23. HOUR 3:00 PM
3. SEX Male	4. RACE White	S. DATE OF BIRTH April, 21, 1884-84	6. AGE (in years less birthday) YRS	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. HOURS	10. MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12c. DATE PRONOUNCED DEAD Month December	12d. HOUR 3:00 PM
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Painter			12b. KIND OF BUSINESS OR INDUSTRY Self Emp.
13a. U.S.J.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Baltimore Ave.-Y.M.C.A.		
14. FATHER'S NAME Russell Stewart		15. MOTHER'S MAIDEN NAME Mary Barnard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. Richard W. Stewart, Cumberland, Md.		ADDRESS Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Shock				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Gastric Hemorrhage				" "			
DUE TO, OR AS A CONSEQUENCE OF (c)		Peptic Ulcer				-----			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED DECEMBER 30, 1968			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 2, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland		(County) Allegany, Md. (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS JAN 2 1969				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16784

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16771			2a DATE OF DEATH @ 9:40 P.M.				2b HOUR	
			Month December 31, 1968		Day	Year	P. M.	
1. DECEASED NAME (Type or print)	First Audra	Middle MYRTLE	Last Taylor	S. DATE OF BIRTH Jan. 20, 1894	6. AGE (In years last birthday) 74	IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
3. SEX Female	4 RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany County			
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	10. CITY OR TOWN OF DEATH Cumberland Allegany County Infirmary			12a. USUAL OCCUPATION AND OF WORK DONE during most of working life, even if retired Retired: Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 723 Lafayette Street	12b. KIND OF BUSINESS OR INDUSTRY Indgarment			
14. FATHER'S NAME Thomas	First F.	Middle Allen	Lost	15. MOTHER'S MAIDEN NAME Mary	E.	Michaels	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO 220-26-7545	17. INFORMANT P.O. Box 599, Allegany County Infirmary records.			Address Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>41a</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <i>Dr. A.S. - Hyp. C.V.D</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>many years</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus - Cerebral Hemorrhage 11/14</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30/</u> , 1965, to <u>Dec. 31, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John A. Tupper MD</i>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>1/4/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>John A. Tupper MD</i>	22e. ADDRESS <i>Hospital, Cumberland, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL(S) (if any)	23b. DATE 1/4/69	23c. NAME OF CEMETERY OR CREMATORIAL Greenway Cemetery	23d. LOCATION (City or Town) Berkeley Springs		(County) Morgan	(State) W. VA.		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.	ADDRESS			25a. REC'D BY REGISTRAR DAWN 8	25b. REGISTRAR'S SIGNATURE <i>Charles J. Geiger</i>			



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16772

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16785

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTI- MATED	Month	Day	Year	2b HOUR	
LUCINDA			MAE	TRIMBLE	<input checked="" type="checkbox"/>		DEC 16	68	215AM		
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years since birthday)	F UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS. HOURS	MIN				
FEMALE	WHITE	APRIL 4, 1906	62 yrs	X							
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNSYLVANIA		U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give state & city)			12a. J.S.A.L OCCUPATION (Kind of work done most of working time)			12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			HOUSEWIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS?					
MARYLAND			MT. SAVAGE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD# 1 BOX 153 MT SAVAGE		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
FORREST					WEYANT	AMANDA			GEORGE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT			ADDRESS		
NO			NONE			FRANCIS A. TRIMBLE RFD# 1 BOX 153 MT SAVAGE					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SKITER											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 410Y DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS Conditions if any, which gave rise to immediate cause (a). stating the underlying cause (b) last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED DEC 16, 1968		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b DATE 18 DEC 68			23c NAME OF CEMETERY OR CREMATORIAL REST LAWN MEMORIAL PARK			23d LOCATION (City or Town) LAVALE		
24 FUNERAL DIRECTOR			ADDRESS H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MD			25a REG'D BY REGISTRAR DEC 19 1968			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

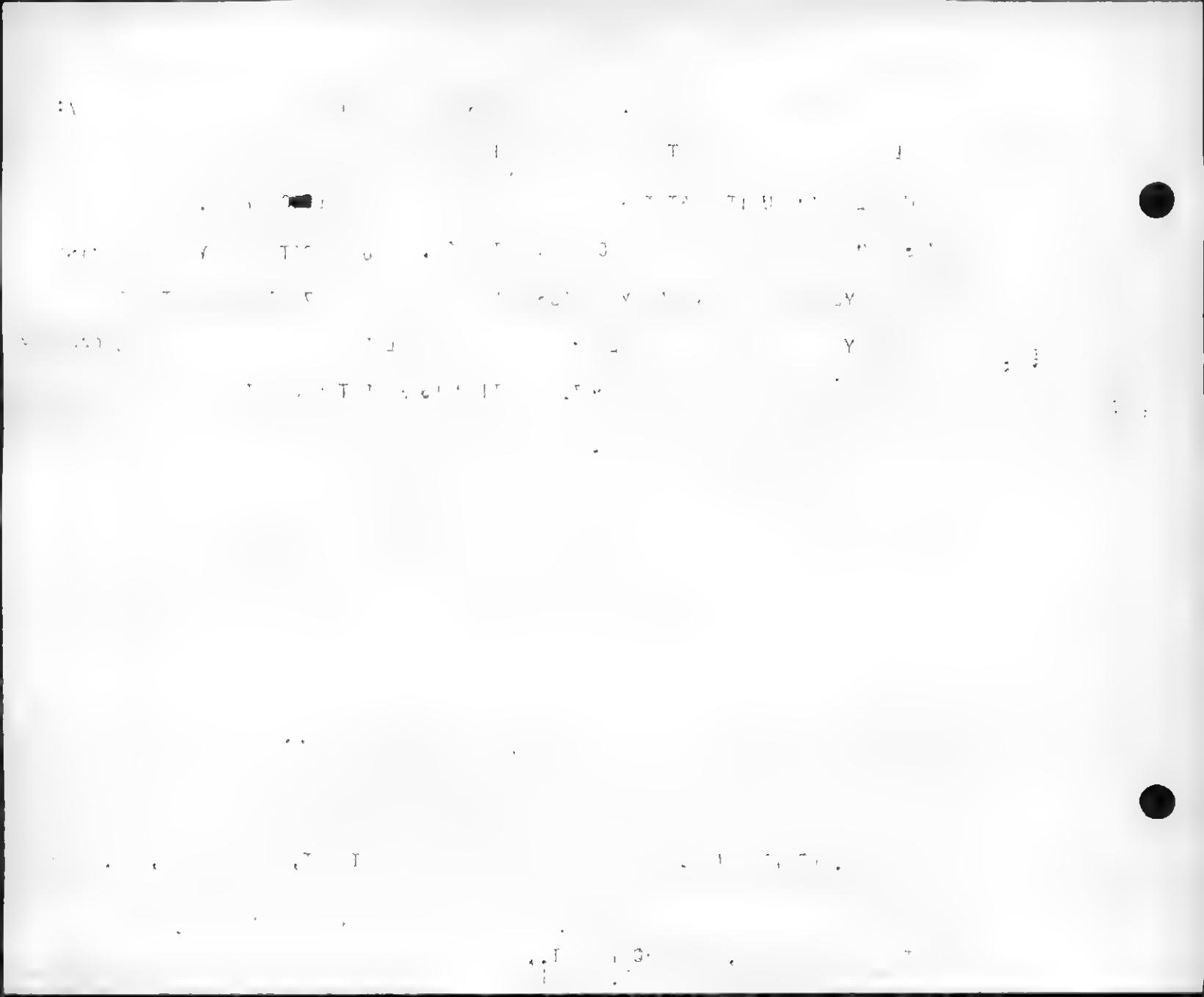
CERTIFICATE OF DEATH

16786

16773

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First HENRY	Middle A.	Last WALKER	2a. DATE OF DEATH Month 12	Year 7 Oct 68	2b. HOUR 7:40AM
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 10/21/96			6. AGE (In years last birthday) 72	IF UNDER 1 YEAR YRS. MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY CO.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SACRED HEART HOSP.			12a. US. At OCCUPATION (Kind of work done during most of working life, even if retired) QUEEN CITY DAIRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	13d. INS. DE CITY LIMITS? YES	13e. STREET AND NUMBER 307 FRANKLIN STREET	12b. KIND OF BUSINESS OR INDUSTRY DAIRY
14. FATHER'S NAME First HARRY		Middle WALKER	Last	15. MOTHER'S MAIDEN NAME First ELLA	Middle	Last	MC CAFFREY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO 214 05 6478		17. INFORMANT PATIENT'S HOSPITAL CHART Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coclericia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>cancer of the lung</i> 1 year DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED Wh. in <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-5-68 , 19 68 , to 12-7-68 , 19 68 , that (I) (we) last saw the deceased alive on 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>L. Brings</i>		DEGREE ATTENDING PHYS	22c. DATE SIGNED 12-7-68				
22d. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS		22e. ADDRESS 57 GREENE STREET, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/10/68	23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		23d. LOCATION (City or Town) Cumberland Allegany Md.	(County)	(State)
24. FUNERAL DIRECTOR KIGHTS FUNERAL HOME, 309 DECATUR ST., CUMBERLAND, MD.		ADDRESS 21502	25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	DATE DEC 13 1968	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

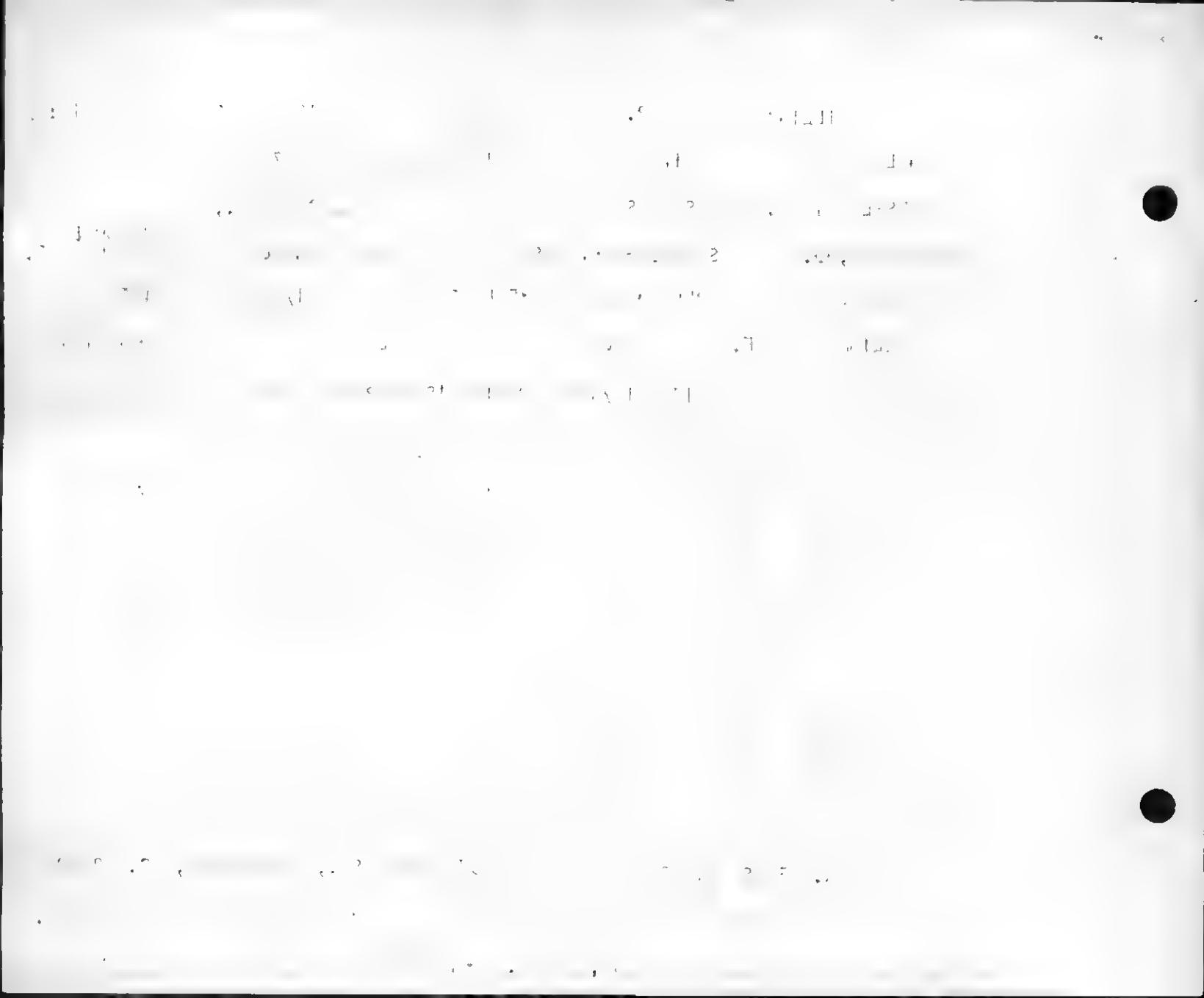
16774

CERTIFICATE OF DEATH

16787

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. DECEASED NAME (Type or print)		First WILLIAM	Middle P.	Lost WENDT	2d. DATE OF DEATH Month 12	Year 68	2b. HOUR 12:45
3. SEX MALE		4. RACE WHITE	S DATE OF BIRTH 12/2/98	6 AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 0	F UNDER 24 HRS HOURS 0
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH ALLEGANY CO., Md.			
10 CITY OR TOWN OF DEATH CUMBERLAND, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BRANCH MANAGER		12b KIND OF BUSINESS OR INDUSTRY NATIONAL BISCUIT CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 817 GEPHART DRIVE		
14. FATHER'S NAME First WILLIAM		Middle F.	Lost WENDT	15. MOTHER'S MAIDEN NAME First CLARA		Middle	Lost WARNICK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 174 01 7500		17 INFORMANT PATIENT'S HOSPITAL CHART		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) <i>coronary sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost. (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) <i>4 days</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 11-29, 1968 , to 12-2, 1968 , that (I) (we) last saw the deceased alive on 12-1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>L. Brings</i>		DEGREE DR.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-3-68	
22d. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS.		22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/68	23c. NAME OF CEMETERY OR CREMATORIUM Graceland Cemetery		23d. LOCATION (City or Town) New Castle, Lawrence, Penna.	(County)	(State)
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 6 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Brings</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16775

CERTIFICATE OF DEATH

16788

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First JAMES	Middle H.	Last WHEELER	2d. DATE OF DEATH Month Day Year 12 23 68	26. HOUR P.M. 8:35 M		
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 4/25/05		6 AGE (In years last birthday) 63	7 IF UNDER 1 YEAR MONTHS YRS	8 IF UNDER 24 HRS DAYS HOURS MIN 00 00 00		
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY					
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital group address) SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during month of death even if retired) MEAT CUTTER		12b KIND OF BUSINESS OR INDUSTRY FOOD MKT.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 120 INDEPENDENCE ST.				
14 FATHER'S NAME First EDWARD	Middle WHEELER	15 MOTHER'S MAIDEN NAME First Middle ANNA ROWAN WHEELER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or No (own) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 214 05 8929	17. INFORMANT SACRED HEART HOSPITAL	Address 900 SETON DRIVE CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mox	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cochlea</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized Cereinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF last <i>Concurrent of Hypopharynx cancer</i> 6 yrs.							1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none								
19a. DATE OF OPERATION 147X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) While at work					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None	21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug. , 1966, to 12/23 , 1968, that (I) (we) last saw the deceased alive on 12/23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Jeffrey J. A. Pagan</i>		22c. DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 12/24/68				
22d. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN		22e. ADDRESS 1068 NATIONAL HIGHWAY CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION Burial		23b. DATE Dec. 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)		
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME - 108 VA. AVENUE CUMBERLAND, MARYLAND		ADDRESS		25a. RECD BY REGISTRAR JAN 3 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
R A15 1 - 169		DATE						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

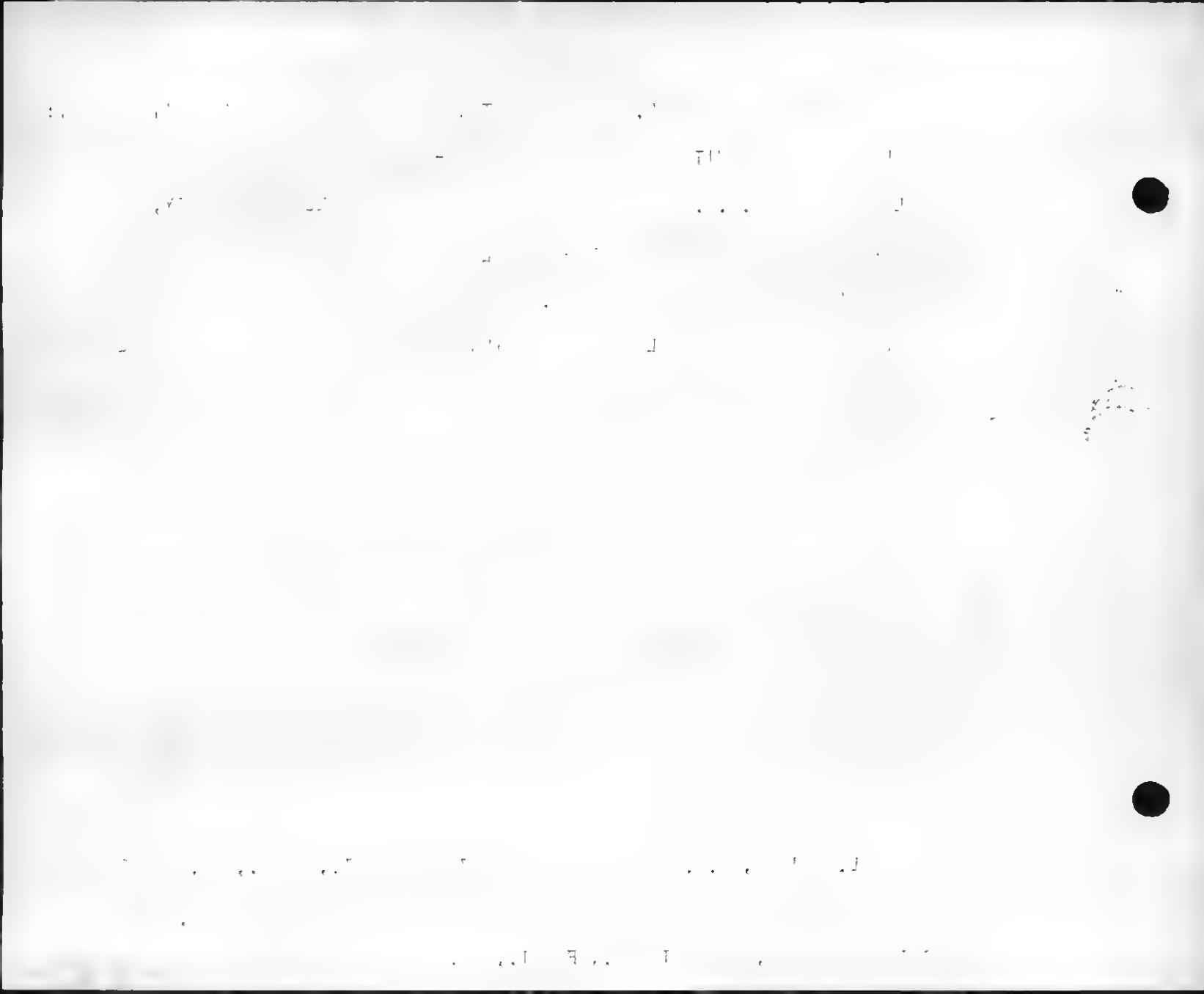
16789

16776

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Post and seal should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First MARY	Middle F.	Last WHORTON	20. DATE OF DEATH Month 12	Day 11	Year 68	2b HOUR P 11:45			
3. SEX		4 RACE		S. DATE OF BIRTH	6 AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH ALLEGANY COUNTY,						
10. CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY BLANK		Md.			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY /		13c CITY OR TOWN MT. SAVAGE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER BLANK					
14. FATHER'S NAME First LEVI		Middle BLANK	Last	15 MOTHER'S MAIDEN NAME First (WILHELM) FANNIE	Middle	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 214-01-0110A		17 INFORMANT HOSPITAL RECORD	Address						
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)				<i>vagopletic stroke</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 120		DUE TO, OR AS A CONSEQUENCE OF (b)		<i>hypertension</i>		13 yrs					
		DUE TO, OR AS A CONSEQUENCE OF (c)		<i>cardio renal vascular disease</i>		2 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 44-X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from 11-29-68 , to 12-11-68 , that (I) (we) lost saw the deceased alive on 12-11-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Lew Brings</i>		DEGREE MD.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-12-68					
22d. PHYSICIAN'S NAME (Type)		L. BRINGS, M.D.		22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-14-68		23c. NAME OF CEMETERY OR CREMATORIUM ST. PATRICKS CEMETERY		23d. LOCATION (City or Town) MT. SAVAGE, MD.		(County) (State)			
24. FUNERAL DIRECTOR DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.		ADDRESS		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16790

1677?

1. DECEASED NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF EST DEATH MATED	Month	Day	Year	2b HOUR
Rose C. Willetts						<input checked="" type="checkbox"/>	Dec. 13,	1968	10a M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F UNDER MONTHS	YEAR DAYS	17. UNDER 24 HRS HOURS	MIN			
Female	White	May 23, 1903	65 YRS							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month Day Year		
Md.		USA		WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	DECEMBER	13, 1968	
10. CITY OR TOWN OF DEATH LaVale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 137 National Highway			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Allegany			13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 137 National Highway LaVale, Md.	
14. FATHER'S NAME First Peter H. Wagner			15. MOTHER'S MAIDEN NAME First Margaret						Middle Lost (Sherry)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No			16b. SOCIAL SECURITY NO None			17. INFORMANT J. William Willetts			ADDRESS 137 National Highway LaVale, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 41-7 DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) CORONARY SCLEROSIS DO TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			BENEDICT SKITARSLIC			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 13, 1968 ADDRESS (Street, city, town or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial 12/16/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Memorial P.			23d. LOCATION (City or Town) Frostburg Allegany Md.			(County) (State)
24. FUNERAL DIRECTOR		William G. Kight Cumberland, Md.			25a. REC'D BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

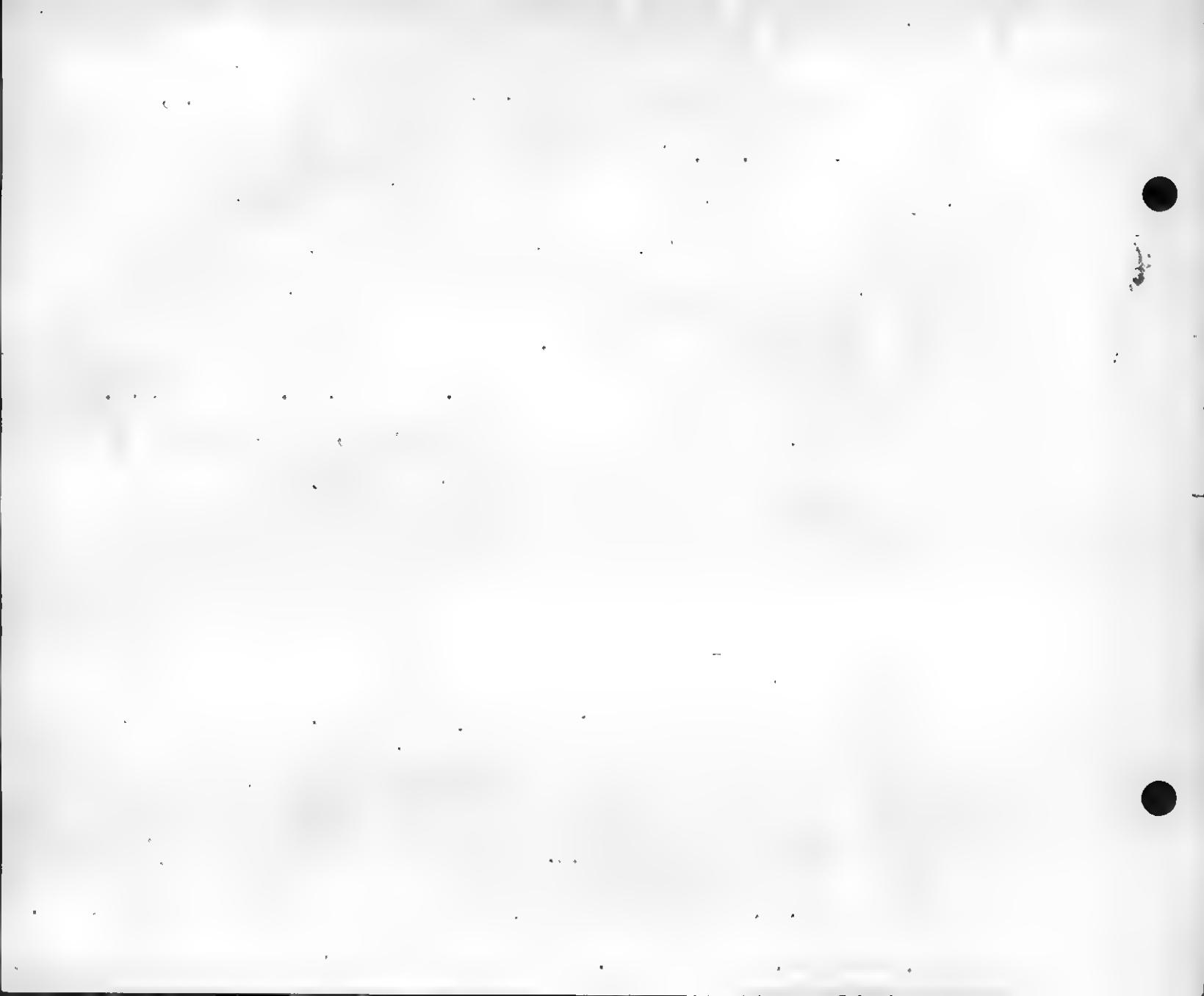
This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16778 16791

1. DECEASED NAME (Type or Print)		First Karen	Middle Jane	20. DATE KNOWN OF ESTI- DEATH MATED	Month DEC. 6, 1968	Day 15	Year 20p	2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Mar. 25, 1960	6. AGE (In years last birthday) 8 yrs	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miner's Hospital--DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.) Student - 3rd Grade Frost Elementr.		
13a. JURAL RESIDENCE (Where deceased lived, if institution Residene before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg	13d. INSIDE CITY, J.M. TSP?	13e. STREET AND NUMBER 19 Park Avenue		
14. FATHER'S NAME First James		Middle Nelson	Last Willison, Jr.	15. MOTHER'S MAIDEN NAME First Dorothy		Middle Elaine	Last Baker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT James M. Willison, Jr., Frostburg, Md.		ADDRESS 19 Park Avenue, Frostburg, Md.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Skull Fracture, Fractured Neck Approximate interval between onset and death Minutes								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (Struck by Automobile) (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION G.VEN IN PART 1(a) 812+								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Struck by Vehicle (Pedestrian)		21b. TIME OF INJURY Month, Day, Year 5 PM Dec. 6 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Struck by Vehicle (Pedestrian)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street Corner of Linden & Water Sts. Frostburg, Alleg. Maryland		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opin on death resulted fram: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 6, 1968 ADDRESS (Street, city, town, or county) Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 9, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg. Md.		
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. RECEIVED BY REGISTRAR John J. Hafer, Jr.			25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME (5) 10M REV 1/68		DATE DEC 10 1968						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certifcate, writing the word "handing" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

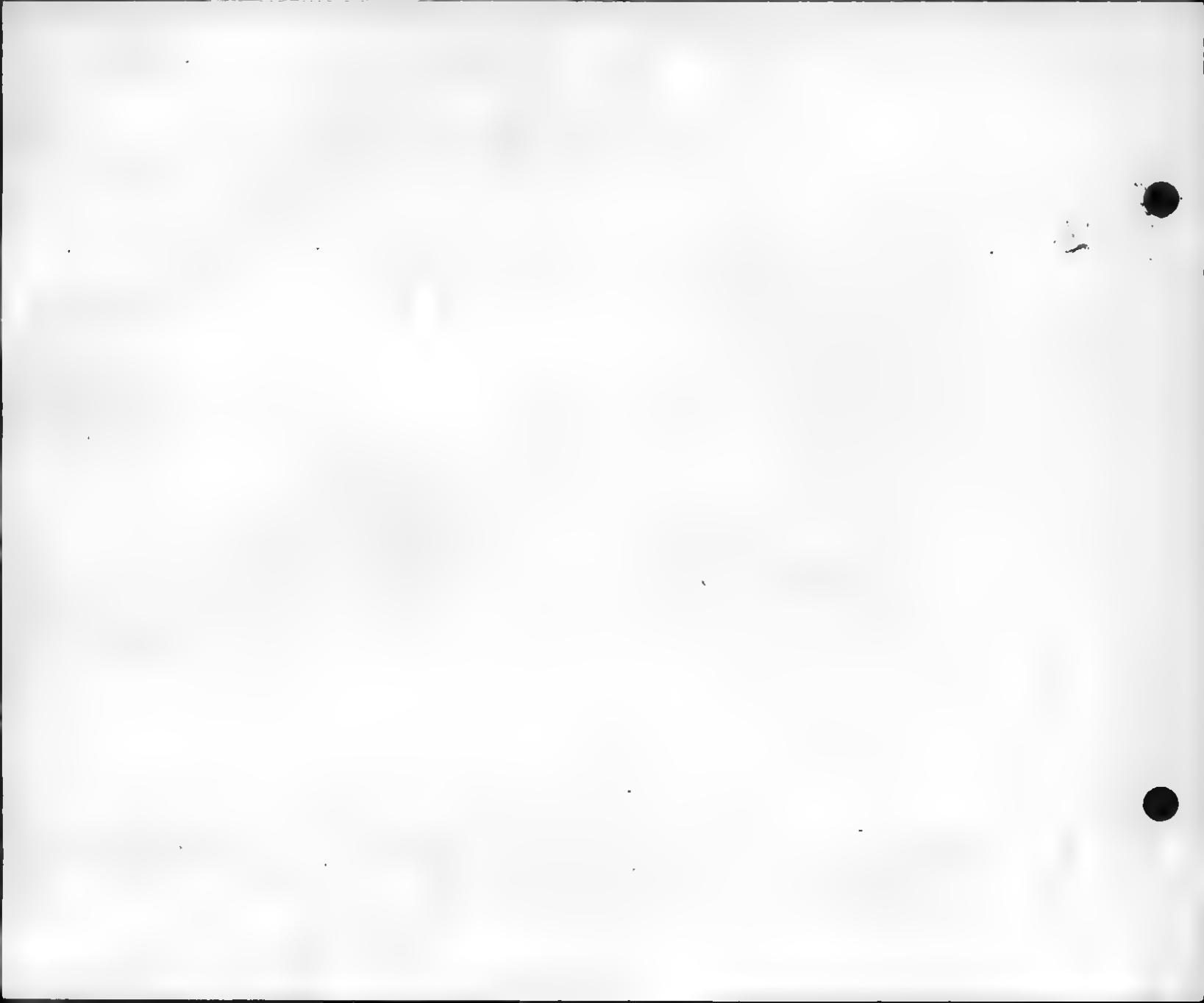
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 3 and 4, and in any event within 72 hours after death.

Item 5 FilmGlo 8
1/6/69 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16792

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH MATED				Month	Day	Year	2b. HOUR
SHELDON			B.	WILLISON		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12	23	68	A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	1905	6. AGE (in years at birthday)	63 yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS						2d HOUR
MALE	WHITE	JAN. 25, 1905		MONTHS	DAYS	HOURS	MIN						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED	NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH	ALLEGANY				Md
PENNSYLVANIA		U.S.A.		WIDOWED	<input type="checkbox"/>	DIVORCED	<input checked="" type="checkbox"/>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			DOA MEMORIAL HOSPITAL				LABORER				VARIOUS		
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
PENNSYLVANIA			BEDFORD		RFD		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	RT. 2, LAKE GORDON ROAD				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last	
RAY WILLISON						LORA BARNES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT				ROUTE 2, CUMBERLAND, MD			
YES			207 10 9368			RAY WILLISON				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause _____ last. (b) DUE TO, OR AS A CONSEQUENCE OF Coronary Occlusion (c) DUE TO, OR AS A CONSEQUENCE OF Coronary Sclerosis													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive cardiovascular disease													
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) BEDEICT SKITARELIC, M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or County) ROUTE 2, CUMBERLAND, MD. DATE SIGNED 12/23/68													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIY				23d. LOCATION (City or Town) (County) (State)			
BURIAL			DEC. 26, 1968			UNION GROVE CEMETERY				CUMBERLAND, MD.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG STRAR				25b. REG STRAR'S SIGNATURE			
BYRON KIGHT			CUMBERLAND, MD.			DEC 30 1968				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

16793

1. DECEASED NAME (Type or print)			First HUGH	Middle W.	Last WILSON	20. DATE OF DEATH DECEMBER 15th, 1968	2b. HOUR 10:00 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-18-01		6. AGE (in years last birthday) 67	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN. 00
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED Paymaster		12b. KIND OF BUSINESS OR INDUSTRY Paper Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13c. CITY OR TOWN LUKE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 303 FAIRVIEW ST.		
14. FATHER'S NAME First ROBERT		Middle WILSON	Last	15. MOTHER'S MAIDEN NAME First SARAH		Middle WATSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO		16b. SOCIAL SECURITY NO. 216-07-9366		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5705		DUE TO, OR AS A CONSEQUENCE OF (b) ? massive Pulmonary Embolism		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) P.O. status (release of interest obstr.)								
19a. DATE OF OPERATION 12/13/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstr.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec 15 , 1968, to Dec 15 , 1968, that (I) (we) last saw the deceased alive on Dec 15 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A. J. Mirkin MD.</i>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED Dec. 15, 1968
22d. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22e. ADDRESS 115 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 19, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery		23d. LOCATION (City or Town) Westernport Alleg. Md.		
24. FUNERAL DIRECTOR W. Harold Fredlock, Jr. Piedmont, W. Va.		ADDRESS		25a. REC'D. BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE <i>Harold Fredlock Jr.</i>		

66701

00:01 03/12/11 03/03/2011

10631-5

571104

00000

10631-5

571104

10631-5 10631-5 10631-5 10631-5

10631-5 10631-5

10631-5 10631-5

10631-5

10631-5

10631-5

10631-5

10631-5

10631-5 10631-5 10631-5 10631-5

00:01 03/12/11 03/03/2011

10631-5 10631-5

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16781

16794

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First BERNARD	Middle F.	Last WOODS	2a. DATE OF DEATH Month 12-09-68	2b. HOUR Day P 9:25 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 07-16-99		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ALLEGANY		Md.
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tire Builder		12b. KIND OF BUSINESS OR INDUSTRY KELLY TIRES	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN ELLERSLIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER ELLERSLIE, MD. 21529	
14. FATHER'S NAME WILLIAM	First Middle WOODS	15. MOTHER'S MAIDEN NAME MARY	Middle Last MC PARTLAND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 214-07-0080	17. INFORMANT PTS HOSP CHART SACRED HEART HOSP	Address CUMB., MD. 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Coronary heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4201		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>12-5</u> , 19 <u>68</u> , to <u>12-9</u> , 19 <u>68</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>12-9</u> , 19 <u>69</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <u>Richard W. Trevaskis Jr.</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED <u>Dec 11, 1968</u>
22d. PHYSICIAN'S NAME (Type) RICHARD W. TREVASKIS JR., M.D.		22e. ADDRESS 200 BALTO AVE., CUMB., MD. 21502			
23a. BURIAL, CREMATION, Burial <input type="checkbox"/> (Specify)		23b. DATE Dec. 13, 1968	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County) (State)
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME		ADDRESS 108 VIRGINIA AVE. CUMBERLAND, MD. 21502	25a. REC'D BY REGISTRAR DATE DEC 16 1968	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

RECORDED

RECORDS

CD

02-11-70

T1E

24H

111-011

020

UVAFN

111-011

111-011

CD-BELU

111-011

111-011

111-011

111-011

3000

111-011

111-011

111-011

111-011

111-011

111-011